Public Health Core Functions
and
Community Health Planning

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PUBLIC HEALTH CORE FUNCTIONS
AND
COMMUNITY HEALTH PLANNING

The three (3) core functions of public health (assessment, policy development, and assurance) developed by the Institute of Medicine's report, *The Future of Public Health* (1988) are widely accepted among public health's policy and academic community. An initial attempt to further define the functions of public health were included in President Clinton's *Health Security Act* (1993). As a result, in 1994 several revised versions began to appear from several different public health groups. In an effort to coordinate a single list for the public health community to use, the Core Public Health Functions Project was developed by Dr. Philip Lee, then Assistant Secretary for Health. A subcommittee of the Working Group, the Essential Services Work Group was formed to further refine the language. The Public Health in America statement subsequently developed was reviewed and adopted by the Core Functions Working Group and Steering Committee. In 1995, the name of this group was changed to the Public Health Functions Working Group and Steering Committee.

The responsibility of local health departments is to protect and promote health, and prevent disease and injury. Public health services are population based services which are focused on improving the health status of the population.

Public health planning is a significant feature of a local health department system. Through the planning process, local public health departments (LHDs) and community health boards assess both their internal capacity and the health of the community, identify priority public health issues, and select appropriate interventions. Planning assures accountability for local, state, and federal funding, and also is an essential process for effectively targeting public services.

The **Essential Public Health Services** provide the fundamental framework for the National Public Health Performance Standards Program (NPHPSP) instruments, by describing the public health activities that should be undertaken in all communities.

The Core Public Health Functions Steering Committee developed the framework for the Essential Services in 1994. This steering committee included representatives from US Public Health Service agencies and other major public health organizations.

The Essential Services provide a working definition of public health and a guiding framework for the responsibilities of local public health systems.
http://www.cdc.gov/od/ocphp/nphpsp/EssentialPHServices.htm

Local health departments should assess their community needs every 3-5 years. LHDs will be asked to submit annually a fiscal year community-based public health activity plan as part of the LHD Budget process.

POPULATION-FOCUSED SERVICES TERMINOLOGY

Public Health is a critical element in the health care system. The services are population-focused; for example, they are services and interventions that protect entire populations from illness, disease and injury. To accomplish their mission, public health agencies balance the core health functions, essential services, and the health activities listed below.

CORE PUBLIC HEALTH FUNCTIONS:

- Assessment
- Policy Development
- Assurance

Essential Public Health Services are the ten broad national services.

NATIONAL ESSENTIAL CORE SERVICES

- Monitor health status to identify community health problems.
- Diagnose and investigate health problems and health hazards in the community.
- Inform, educate, and empower people about health issues.
- Mobilize community partnerships to identify and solve health problems.
- Develop policies and plans that support individual and community health efforts.
- Enforce laws and regulations that protect health and ensure safety.
- Link people to needed health services and ensure the provision of health care when otherwise unavailable.
- Assure a competent public health and personal health care workforce.
- Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
- Research for new insights and innovative solutions to health problems.

Kentucky's LHD Representatives and the Department of Public Health have defined core Public Health Activities as specific activities of LHDs.

KENTUCKY ESSENTIAL CORE SERVICES REQUIRED BY STATUTE OR REGULATION

- Enforcement of Public Health Regulations
- Surveillance of Public Health
- Communicable Disease Control
- Public Health Education
- Public Health Policy
- Families and Children Risk Reduction
- Disaster Preparedness

Mandated Services
Required of all Public Health Departments

Seven Core Services Required by Statute or Regulation	**Six Preventive Services for Specific Populations from Appropriated Funds**
Enforcement of Public Health Regulations	Family Planning
Surveillance of Public Health	Prenatal Care
Communicable Disease Control	Well Child Care
Public Health Education	Women, Infants, and Children (WIC)
Public Health Policy	Adult Preventive Services
Families and Children Risk Reduction	Chronic Disease Monitoring and Support
Disaster Preparedness	

The services listed above are required for all LHDs. The authority of core activities exists in the Commonwealth of Kentucky's statutes or regulations. The authority for preventive services is found in state budget language and in grants and contracts with agencies of the United States Public Health Service. These preventive patient services were added as state and federal governments appropriated the funds.

Local Option Services
Provided after Mandated Services are Assured

Other Population-Based Services (Negotiated Services) i.e., health fairs, diabetes, support groups	**Other Services for Individuals (Negotiated Services) i.e., home health, and school health**

LHDs at their discretion offer Local Option Services. Statute or regulation permits but does not mandate these services. LHDs participating in these activities are expected to be able to compete in the medical marketplace without requiring support from state-appropriated funds. If a community elects to subsidize these services after mandated services have been adequately funded, that is the community's prerogative.

DEFINITION OF SEVEN CORE SERVICES REQUIRED BY STATUE OR REGULATION

Enforcement of Public Health Regulations
LHDs enforce public health regulations by providing oversight, education, and assurance of compliance with federal, state, and local public health laws designed to protect and promote the health of the public.

Surveillance of Public Health
Surveillance is a process of monitoring public health conditions by the ongoing collection, analysis, and sharing of information. The data gained from surveillance is used to help develop programs to improve well being and health in the Commonwealth of Kentucky.

Communicable Disease Control
Communicable disease control is the process through which LHD prevent the spread of infectious disease. The key activities include immunizations, investigations and treatment of outbreaks, and public education.

Public Health Education
LHDs inform and educate individuals, groups, and communities about good health in order to promote health lifestyle choices and mitigate health risks.

Public health education also provides critical information that safeguards health and safety in response to disasters or other health crises.

Public Health Policy
Public health policy encompasses the broad standards and framework that govern a community's public health activities. Policies are based on data from surveillance and the public's directives, usually from public officials, based on that information. Policies are often initiated at the national level but defined and refined to meet needs identified at the state and local levels.

Families and Children Risk Reduction
LHDs reduce health risks and problems in the community by identifying and providing needed services or referring individuals to other appropriate providers.

Disaster Preparedness
In collaboration with other disaster and emergency service providers, LHDs develop and maintain policies and procedures for responding to disasters. While communities may never actually experience a disaster, some level of preparation is required.

DEFINITION OF PREVENTIVE SERVICES FOR SPECIFIC POPULATIONS FROM APPROPRIATED FUNDS

Family Planning
LHDs provide family planning services that consist of educational, medical, and social services to help individuals voluntarily determine the number and spacing of their pregnancies and children.

Prenatal Care
LHDs provide prenatal care prior to pregnancy, during pregnancy, and for six weeks after pregnancy to promote the physical and mental well-being of the pregnant women and her infant and family.

Well Child Care
LHDs provide a series of preventive health check-ups for children from birth through 20 years of age who are not receiving well child care from another health provider.

Women, Infants, and Children (WIC)
LHDs provide nutrition education and healthy foods to pregnant, breastfeeding, and post delivery women, infants and children who meet income and health risk guidelines.

Adult Preventive Services
LHDs provide or arrange for age-appropriate health screenings or services for eligible adults as requested by the individual. Services may include a partial or complete health screening.

Chronic Disease Monitoring and Support
LHDs provide screening for certain chronic diseases, such as diabetes and high blood pressure. The LHD also provides follow-up education and support for people with these conditions.

DEFINITIONS OF LOCAL OPTION SERVICES PROVIDED AFTER MANDATED SERVICES ARE ASSURED

Other Population-Based Services
LHDs provide population-based services to groups of people rather than to individuals. Examples of negotiated population-based services include: a health fair, a walking program for senior citizens, or a diabetes support group in a high school.

Other Services for Individuals
LHDs provide services for individuals and are paid through a contract with an individual's doctor or another payment source. An example of a negotiated service includes a LHD's contract with a school to make home visits to all children prior to their entering kindergarten. Another example is a local employer's contract with the LHD to provide flu shots to their workers to reduce absenteeism.

DESCRIPTION OF SEVEN CORE SERVICES REQUIRED BY STATUTE OR REGULATION

(Please note that information contained in this section is not all-inclusive of the descriptions of the seven core services required by statute or regulation.)

1. Enforcement of Public Health Regulations

LHDs enforce public health regulations by providing oversight, education, and assurance of compliance with federal, state, and local public health laws designed to protect and promote the health of the public.

The Scope of Public Health Regulations

The scope of regulations includes sanitation and safety, vital statistics, medical enforcement, city and county ordinances, and local boards of health regulations.

Sanitation and Safety

These include:

- Inspection of restaurants and groceries for safe food
- Inspection of septic systems to prevent public exposure to sewage-borne diseases
- Inspection of public facilities: schools, swimming pools, mobile home and RV parks, hotels and motels, and state confinement facilities
- Vaccination of animals against rabies and quarantine of animals who have bitten persons

Vital Statistics

These include:

- The local registrar records births, fetal deaths, and paternity affidavits.
- The local registrar assists parents in completing and filing certificates for home births.

Medical Enforcement

These include:

- Communicable disease reporting, investigation and follow-up, for example, tuberculosis, sexually transmitted diseases (STDs)
- Screening of newborns for specific conditions and follow-up testing as needed
- Assurance of timely childhood school immunizations
- Rabies control which assures immunization of exposed patients

City and County Ordinances and Local Board of Health Regulations

These include:

- Enforcing connection to sewers
- Minimum size for septic systems
- Domestic animal immunizations
- Food handler training and certification

Methods used in Enforcement of Public Health Regulations:

LHDs carry out the enforcement of public health regulations through the following means:

Sanitation and Safety

- Routine inspections, complaint inspections
- Permits, licensure, certification
- Initiation of court action by means of criminal complaints or injunctions
- Administrative action: hearings, notice to correct violations, quarantine or destruction of unsafe food, or permit suspension revocation
- Education and training of regulated businesses, individuals, and groups
- Education of general public through press releases, public advisories, or public presentations

Vital Statistics

- Educate medical providers on proper reporting procedures and supply appropriate forms
- Review records/certificates to assure proper completion
- Completing, collecting and transmitting original records to the Vital Statistics Office to assure a comprehensive database

Medical

- Reviewing immunization records to assure compliance with immunization requirements
- Educating the public and school personnel on immunization requirements
- Conducting public information campaigns through back-to-school clinics, health fairs, and community events
- Collaborating with medical providers to assure that follow-up newborn screening is conducted when necessary
- Educating medical providers on disease reporting requirements

Why do LHDs enforce Public Health Regulations?

- Mandated by Kentucky law
- To protect and promote the health and safety of the citizens of the Commonwealth by assuring compliance with all applicable federal, state, and local laws
- Citizens can make informed, proper health decisions when educated.

Who benefits from Public Health Regulations?

Everyone who lives in or travels through the Commonwealth of Kentucky benefits from enforcement of public health regulations.

Positive health outcomes for our communities as a result of LHDs enforcing Public Health Regulations:

- Health care costs are reduced
- Food and lead-based paint poisonings are reduced
- Food-borne communicable diseases are prevented
- Sewage and water-borne diseases are prevented
- The transmission and spread of communicable, food, water, and animal-borne diseases are prevented

- Children are protected from injury and illness in schools and other public facilities
- Human rabies deaths are prevented

2. Surveillance of Public Health

Surveillance is a process of monitoring public health conditions by the ongoing data collection, analysis, and sharing of information. The data gained from surveillance is used to develop programs to improve well being and health in the Commonwealth of Kentucky.

The Scope of Surveillance of Public Health:

- Estimates the extent of the health problem: normal numbers, epidemic or a rare event, such as, diabetes, cancer, vehicular injuries, or influenza
- Determine the exact location of cases, such as, cervical cancer in Eastern Kentucky, whooping cough in a community, farm injuries, or syphilis in an urban county
- Describes the natural course of a disease ranging from a case of food poisoning, rabies from an animal, or inherited conditions
- Monitors changes in the nature of infectious agents: the evolution of multiple drug-resistant TB
- Monitors introduction of newly recognized disease: Lyme disease and AIDS
- Evaluates control measures and changes in health practices, such as, changes in TB therapy or seat belt use
- Tracks lifestyle changes
- Facilitates planning and policy development of, for example, head lice prevention or teenage sexual abstinence programs

Methods used by LHDs in surveillance:

- Reportable disease/condition reports; mapping of location of event
- Collection of laboratory specimens and reports; one-on-one interviews
- A random telephone survey of behavioral risk factors, community needs assessment at LHD
- Vital statistics—recording of births and deaths
- Collection of immunization compliance records
- Education – *Epi Note and Reports,* new media, local workshops with community and professional groups
- Contact physicians and hospitals for disease information

Why do LHDs practice Surveillance of Public Health?

- This is a core public health function mandated in Kentucky law and administrative regulation.
- Enforcement and surveillance information drives other core public health functions.

Who Benefits from Surveillance of Public Health?

- People who live, work, and visit in Kentucky

Positive health outcomes for our communities because LHDs practice Surveillance of Public Health:

- Rapid identification and control of infectious disease and health conditions
- Decrease in premature death
- Decrease in expenditures on health care
- Early detection of health problems

- Prevention of disease and complications
- Increased productivity of the workforce
- Improved quality of life as well as improved medical and health practices
- Decrease in disabilities
- Improve access to health care

3. Communicable Disease Control

Communicable disease control is the process through which LHD prevent the spread of infectious disease. The key activities include immunizations, investigations and treatment of outbreaks, and public education.

The Scope of Communicable Disease Control

- Reporting of disease from the community is required of physicians and laboratories.
- Investigation of illness
- Stop the spread of illness and prevent complications
- Prevention of future outbreaks

Methods used by LHD to practice Communicable Disease Control:

- Immunization clinics, including flu vaccinations given throughout the community
- Education of community agencies on new regulations and how to report infectious disease through handouts, one-on-one, and classes
- Investigation, treatment, and prevention of sexually transmitted diseases
- Review of daycare and school immunization records to ensure that children are properly immunized
- Investigation of environmental hazards, for example lead poisoning in children, sewage contamination of local water supply, or prevention of diarrhea at swimming pools
- Investigation of animal bites and prevention of fatal rabies outbreaks

Why do LHDs provide Communicable Disease Control?

- Mandated in Kentucky law and administrative regulation
- Prevention of disease assures a healthier community

Who benefits from Communicable Disease Control?

Every citizen and visitor benefits from communicable disease control.

Positive health outcomes for our communities because LHD practice Communicable Disease Control:

- Children are immunized and protected from communicable disease.
- A healthy workforce is a productive workforce.
- Communicable diseases are detected early, and measures taken to control their spread in the community.
- Prevention costs are substantially less than treatment

4. Public Health Education

LHDs inform and educate individuals, groups, and communities about good health in order to promote healthy lifestyle choices and reduce health risks.

The Scope of Public Health Education

Provides critical information that safeguards health and safety in response to disasters or other health crises and is episodic or ongoing depending on the event:

- Informs the public about a *boil water* advisory during a flood
- Educates the public about what to do in the event that there is a flash flood alert, tornado watch or warning, or other weather emergency
- Educates parents about the need for working smoke detectors in the home and what to do in the event of a fire

Promotes positive health behaviors and reduces or eliminates health risk behaviors:

- Educates women of childbearing age about folic acid supplements to prevent certain birth defects
- Instructs individuals and groups to purchase and prepare foods that are high fiber and low fat in order to reduce risk of heart disease and certain cancers
- Conducts smoking cessation classes
- Provides health education in the schools to reduce risky behaviors and promote healthier lifestyles
- Conducts screenings to determine personal risk for disease or injury

Focuses on the health of the entire community for which everyone shares responsibility:

- Facilitates a community's need assessment to identify and establish priorities of health issues
- Advises the public regarding the health status of the community
- Convenes and coordinates community resources to address local needs

Methods used by LHDs for Public Health Education:

- One-on-one and group education classes, presentations, and demonstrations
- Targeted media communications, for example, public information campaigns
- Dissemination of health information
- Community health screening and education at health fairs, churches, community events, and senior citizen's centers
- Community development initiatives to share resources and promote joint efforts among individuals and organizations—schools, churches, clubs, and agencies who share an interest in health

Why do LHDs provide Public Health Education?

- The foundation of public health is built on the protection and promotion of health.
- Positive health skills are an important resource for everyday life as we make decisions that affect our heath and quality of life now and for the future.
- Health education's emphasis on prevention helps to reduce health care costs.
- At the heart of public health education is the empowerment of individuals and our communities to achieve ownership and control leading to better health.
- Mandated by Kentucky law

Who Benefits from Public Health Education?

- Public health education is targeted to individuals, groups, and the entire community.

- School-aged children, senior citizens, young parents, teenagers, young adults, middle-aged adults, infants and small children
- Everyone benefits from public health education.

Positive Health Outcomes That Regularly Occur in Our Communities Because of Public Health Education:
Following are a few of many positive health outcomes that regularly occur in our communities as a result of the public dollars spent on public health education. Kentuckians take steps to make themselves healthier and to eliminate or reduce their health risks:

- Women perform monthly breast exams and know the importance of having regularly scheduled mammograms and Pap tests.
- Motor vehicle drivers and passengers have their seatbelts fastened; infants and small children are properly secured in car seats.
- Teens abstain from having sex.
- Adults and children engage in regular exercise and eat healthier foods.
- School children wash their hands after going to the toilet and before eating.
- Pregnant women don't smoke or drink alcohol.
- Men have PSA tests, which screen for prostate cancer.
- Persons with chronic diseases are better able to manage their disease.
- Adults become more aware of their health status.

5. Public Health Policy
Public health policy encompasses the broad standards and framework that govern a community's public health activities. Policies are based on data from surveillance and the public's directives, usually from public officials, based on that information. Policies are often initiated at the national level but defined and refined to meet needs identified at the state and local levels.

The Scope of Public Health Policy
- Public health policies guide local boards of health in setting community priorities.
- Public health policy can vary with geographic, cultural, political, and economic aspects of the area. An example is the tobacco economy in Kentucky that complicates a tobacco education program.
- The health or medical resources available in the service area affect other objective aspects of the scope of public health policy. For example, rural areas are generally underserved with health services.
- Public health policy focuses on the health of the entire community.

Why do LHDs practice Public Health Policy?
LHDs implement and execute policies to comply with Kentucky's laws, regulations, or other directives.

Methods used by LHD to develop Public Health Policy:
- Community needs assessment and monitoring
- Targeted media communications
- Community development initiatives to promote sharing of resources and joint efforts among community organizations

Who benefits from Public Health Policy?
Public health policy works to benefit the entire community.

Positive health outcomes that regularly occur in our communities because of Public Health Policy:

- Reduction in teen pregnancy rate
- Increased birth weights from comprehensive prenatal care
- Decreased childhood illnesses through immunization rates
- Increased quality of life through on-site sewage regulations
- Improved health status
- Improved economic status
- Decrease in rate and reduction in morbidity of all communicable diseases due to early intervention, tracking, and education
- Increase in commercial food service quality through adherence to the food code
- Decreased child morbidity and mortality from motor vehicle misuse because of car seat education and distribution

6. Families and Children Risk Reduction
LHDs reduce health risks and problems in the community by identifying and providing needed services or referring individuals to other appropriate providers.

The Scope of the Service
LHDs reduce risk to families and children by assuring access to needed services:

- Provide preventive health care examinations and ongoing health education by means of prenatal and well child care
- Identify risky behaviors: smoking, lack of exercise, alcohol abuse, lack of seat belt use
- Advocate use of safety seats and restraints and helmets for children
- Provide education regarding sexual activity that may lead to HIV infection or other sexually transmitted diseases
- Conduct health screenings for women and men—blood pressure, mammograms, cholesterol screening, diabetes screening, pap smear, and prostate screening
- Provide information on childhood and adult injuries
- Increase public awareness about exposures to hazards in the environment, violence, and adult and child abuse

Methods used by LHDs to practice Families and Children Risk Reduction:

- Direct care services provided by the LHD staff in community settings
- Working with a community for after-school activities
- Conducts programs to reduce teens' sexual risks
- Develop local network of community providers to address all areas of medical risk

Why do LHDs provide this service?
Public health's role is to promote health and to prevent disease, disability, and premature death regardless of where the service is provided.

Who benefits from Families and Children Risk Reduction?

- The entire population
- Special high-risk groups or populations
- Uninsured

- Overburdened families
- Pregnant and parenting teens

Positive health outcomes for our communities that regularly occur as a result of LHD providing Families and Children Risk Reduction:

- Everyone may receive preventive health care.
- Vaccine preventable diseases are significantly reduced.
- Enhance public understanding of risk from using tobacco, drugs, and alcohol and resources for dealing with the problem.
- Children and adults are properly restrained in motor vehicles.
- More teens abstain from sexual activity.
- More adults practice safer sex.

7. Disaster Preparedness

In collaboration with other disaster and emergency service providers, LHDs develop and maintain policies and procedures for responding to disasters. While communities may never actually experience a disaster, some level of preparation is required.

The Scope of Disaster Preparedness Planning

- Participate proactively in local planning for disaster response and recovery
- Establish cooperative relationships with disaster responders in the community in order to communicate their respective functions, capabilities, and availability during a disaster
- Design, implement, and exercise coordinated disaster responses and recovery plans
- Educate, train, and equip public health staff
- Provide public information on individual, and family unit disaster preparedness

Response

- Work in partnership with other disaster responders to provide emergency response services geared to priority need of the community
- Provide services which may include emergency medical treatment; biological, chemical, or radiological response; environmental monitoring; and administrative services
- Participate in damage assessment teams to evaluate disaster impact and resource capabilities

Recovery

- Assist the community in returning to pre-disaster level of functioning, while continuing to assess the needs of individuals and groups
- Debrief staff and evaluate the disaster response
- Provide surveillance and collection of epidemiological data that will improve the response to the next event

Methods used by LHDs to practice Disaster Preparedness:

- Collaborate with a variety of potential community service providers to ensure awareness of roles and functions to promote effective and appropriate services through the American Red Cross, Salvation Army, local Emergency Medical Services, fire police, and social service agencies
- Develop pre-disaster community site profiles to identify disaster-prone areas, i.e., flood planes, chemical plants; vulnerable population, i.e., nursing homes, mental health residential care sites, or pockets of non-English speaking people; pre-designated mass shelter sites.

- Provide trained staff—public health nurses, environmentalists, and registrars—who are qualified to adapt to the community's disaster needs
- Assess life support systems—water, food, and shelter; and assist with mass feeding, solid waste, sewage disposal, and vector control problems
- Prevent, monitor, and control the spread of communicable disease
- Disseminate education materials and media releases covering communicable disease control, immunizations criteria, damage assessment, food and water safety, and salvage and safe clean-up
- Work with coroners for disposition and retention of bodies
- Remain alert for medical and psychological health problems and environmental health hazards

Why do LHDs prepare for disasters?

- Disasters constitute a major public health risk.
- Prevent or lessen the damaging effects and consequences to human health
- Ensure effective and proven public health measures that will prevent much of the death, injury, disease, and economic disruption caused by disaster
- Mandated by Kentucky law

Who benefits from Disaster Preparedness?

Every citizen benefits from disaster preparedness. Disaster preparedness and planning help to save lives.

Positive health outcomes for our communities because of Disaster Preparedness:

- Because of a health advisory from her LHD, a woman is prevented from poisoning her family by serving home-canned foods contaminated by floodwaters.
- An entire community surrounded by floodwaters for days can proceed with clean up without worrying about tetanus because a public health nurse came by boat to give tetanus shots.
- After a tornado destroys their homes, people in mass shelter don't have to worry about food-borne illness from the food being served, because an environmentalist has done a food safety inspection of the food preparation and serving.
- A Kentucky community can continue to function with minimal disruption after a tanker truck containing a deadly chemical overturns, spilling its contents, because an environmentalist participated in the clean-up to assure that the environment was safe.
- Months after a chemical spill the children in this community can swim, and the fish are alive in a nearby lake because public health environmentalists assessed the risk of contamination and assured that there were no increased risks to human health.

DESCRIPTION OF PREVENTIVE SERVICES FOR SPECIFIC POPULATIONS FROM APPRORIATED FUNDS

(Please note that information contained in this section is not all inclusive of the descriptions of the preventive services for specific populations from appropriated funds.)

1. Family Planning

Family planning consists of educational, medical, and social services to help individuals voluntarily determine the number and spacing of their pregnancies and children.

The Scope of Family Planning

The full scope of family planning means that services are offered in a competent, non-discriminatory, non-coercive manner that respects patient confidentiality.

- **Medical**
  - Teach abstinence
  - Provide a comprehensive physical exam, including necessary laboratory testing
  - Offer pregnancy testing
  - Screen, diagnose, and treat detected STDs
  - Offer all FDA approved methods of contraception that are offered on site or by referral
- **Counseling**
  - Teach abstinence
  - Assist clients in reaching an informed decision regarding the choice and continued use of birth control methods and services
  - Offer basic infertility services
  - Inform clients of pregnancy outcome services. Abortion is not a method of birth control
  - Provide counseling on health risk including counseling prior to conception, HIV/AIDS, domestic violence, substance abuse, and teen-coercive sex
  - Provide counseling that is appropriate for the patient's age, language, cultural background, and understanding

Methods used by LHDs for Family Planning:

- Medical clinics in LHDs and at community satellite sites
- One-on-one and group education classes, presentations, and demonstrations
- Social marketing and targeted media communications
- Community partnerships with hospitals, churches, and other agencies

Why do LHDs provide Family Planning?

- Assure universal access to family planning services
- Prevent unintended pregnancies
- Assure healthy pregnancy outcomes—healthy moms, babies, and families
- Empower individuals to make informed decisions that affect their health and parenting skills
- Reduce incidence of STDs
- Comply with federal and state law

Who benefits from Family Planning?

- All Kentuckians benefit.

- The individuals receiving the service and their families
- The community and Kentucky's health care system

Positive health outcomes that regularly occur in our communities because LHDs provide Family Planning:

- Families realize a positive social and economic impact when births are planned.
- Promotes health and well being.
- Reduces unintended pregnancies, including births to teenagers
- Children are planned and wanted
- Decreases STDs
- Decreases infertility
- Provides early detection of cancer
- Decreases premature births
- Detects early on any acute or chronic health problems
- Enhances other community programs for example, rape crisis and child advocacy
- Provides FDA approved safe birth control methods
- Increases education awareness in a manner that is age, language and culturally appropriate

2. Prenatal Care

LHDs provide prenatal care prior to pregnancy, during pregnancy, and for six weeks after pregnancy to promote the physical and mental well being of the pregnant woman and her infant and family.

The Scope of Prenatal Care

Preconception (prior to pregnancy) counseling is provided to all women of childbearing age with the purpose of identifying conditions, or risks, that could result in a poor outcome of a future pregnancy but may be changed with lifestyle changes or early intervention prior to conception.

Prenatal (during pregnancy) care provides health education during pregnancy about issues that can affect the physical and mental well being of the pregnant woman and her family, in addition to ensuring that all pregnant women receive early and adequate medical care from an appropriate health care provider.

Postpartum (after-delivery) care involves assessing the physical and emotional health of both the mother and her newborn to provide the counseling and support needed to identify and address problems within the family.

Methods of Prenatal Care practiced by LHDs

Preconception:

- Provide individual counseling to identify risk factors: tobacco use or substance abuse, domestic violence, inadequate resources, and prevention of risks, for example emphasizing the importance of folic acid or the need for early and consistent prenatal care
- Provide community-based group presentations at churches, schools, women's groups and other community sites as well as in LHDs.

Prenatal:

- Ensure that medical care is provided to all pregnant women either at a LHD or through joint efforts between private health care providers and the LHD.
- Provide individual health counseling to pregnant women and their significant others so they are educated to recognize normal and abnormal pregnancy changes and recognize when additional care is needed to reduce the number of poor pregnancy outcomes.
- Provide group education activities within the community: breastfeeding, nutrition, parenting, and childbirth education classes.
- Provide professional nursing and para-professional home visiting services with the goal of identifying potential or actual problems, and providing appropriate referrals and support.

Postpartum:

- Provide outreach and home visiting services with the goal of assisting the mother, newborn, and family in obtaining well-baby care, immunizations, WIC services, and family planning services.
- Provide appropriate medical examination and effective contraception, as indicated by need.

Why do LHDs provide Prenatal Care?

- Ensuring a healthy pregnancy outcome contributes significantly to strengthening the family unit, reducing health-care expenditures, and contributing to health and productive citizens.

Who benefits from Prenatal Care?

Women of childbearing age and their families benefit.

Positive health outcomes that regularly occur in our communities because LHD provide Prenatal Care:

- Maternal and infant deaths are reduced.
- Reduction in maternal and infant morbidity.
- Birth defects, particularly neural tube defects and fetal alcohol syndrome, are reduced.
- The numbers of premature and low birth weight babies are reduced.
- Reduction in the number of children with developmental disabilities: blindness, deafness, cerebral palsy, and mental retardation.
- Women are more likely to reduce unhealthy behavior prior to and during pregnancy.
- The family unit is strengthened.
- Reduction in the incidence of unwanted children.
- Partner abuse and child abuse are reduced.
- Reduction in health care costs and financial drain on Kentuckians.

3. Well Child Care

LHDs provide a series of preventive health check-ups for children from birth through 20 years of age who are not receiving well childcare from another health provider.

The Scope of Well Child Care:

- Assess the child and his environment through a complete history and physical examination
- Perform mandated newborn screening for PKU, Congenital Hypothyroidism, Galactosemia, and Sickle Cell
- Educate parents about early brain development, safety, nutrition, dental health, social and emotional needs, lead poisoning, illness prevention, smoke-free environments, and risk behaviors for adolescents
- Educate parents regarding injury prevention, motor vehicle safety, fire safety, water hazards, bicycle safety, and poison control
- Screen for growth and development
- Provide vision and hearing screenings
- Provide age-appropriate immunizations
- Link family to a medical home whenever possible
- Refer for diagnosis and treatment of suspected conditions

The methods used by LHDs to perform Well Child Care:

- Identify families in need of preventive health services
- Collaborate with other community agencies and organizations—schools, day care centers, and camps—to reach children in need of well child care
- Accept referrals from other community providers

Why do LHDs provide Well Child Care?

- Provide for early screening and detection of illness
- Promote routine physical check-ups for children
- Educate parents about the child's health and development
- Mandated by federal and state laws

Who benefits from Well Child Care?

- Children and their families
- Communities, schools, and day care centers

Positive health outcomes for our communities because LHDs provide Well Child Care:

- Children are immunized.
- Increase the average daily attendance in schools
- Reduce high-risk behaviors: substance abuse, teen sexual activity, and tobacco abuse
- Increase knowledge of parents regarding early brain development, childhood safety, and nutrition
- Developmental disabilities are identified and care is secured.
- Children receive preventive health care on a routine basis.
- Parents are education regarding early child development and childhood safety and nutrition.
- Health risk behavior among children and youth are reduced.

4. WIC Program

Program Description:

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC Program) provides nutrition education, breastfeeding promotion and education, referrals for other health and social care services and healthy foods to pregnant, breastfeeding and post delivery women, infants and children up to the age of five (5) who meet income and health risk guidelines.

The Scope of WIC:

Nutrition Education

- Recommended infant feeding guidelines
- Recommended feeding guidelines for women and children
- Planning a healthy diet
- Wise Shopping ideas

Breastfeeding Education and Promotion:

- Reasons to breastfeed
- Benefits of breastfeeding
- Education for public and private entities
- Assistance with breastfeeding

Healthy Foods for Women and Children:

- Low fat milk and cheese for participants over 2
- Eggs
- Fresh fruits and vegetables
- Iron fortified and whole grain cereals
- 100% fruit juice
- Whole grain breads and whole grain products
- Peanut butter, beans or peas
- For Infants: formula, cereal and infant fruits and vegetables

Referrals:

- Prenatal services
- Well-child care
- Immunizations
- Medical nutrition therapy
- Community services
- Social services

Methods used by health departments for the WIC Program:

The local health department determines if the applicant is a categorically eligible pregnant, breastfeeding or post delivery woman, infant or child under the age of five.

The applicant must provide proof of the following:

- Identity
- Resident of the Commonwealth of Kentucky
- Income
    - Household income less than or equal to 185% of poverty level
    - Applicant receives Food Stamps, KTAP or Medicaid

- Household contains a pregnant women or infant receiving Medicaid
- Household member receives KTAP

A health professional determines the applicant's nutritional risk based upon national guidelines and prescribes a food package based on the applicant's category and any special circumstances such as being homeless. The health professionals provide nutrition education in individual or group sessions. Each WIC participant receives counseling on:

- The effects of alcohol and/or tobacco on the woman, fetus and child. This includes counseling on smoking cessation and the effects of second hand smoke.
- Recommendations not to use drugs such as marijuana, cocaine, etc.
- Recommendations not to drink alcohol.
- Recommendations to engage in 30 minutes of physical activity for women and 60 minutes for children each day.

Pregnant women and post delivery women receive breastfeeding promotion and education. The health professionals provide referrals for the following services: immunization, medical nutrition therapy (extensive individualized diet counseling), Well child services, social services, community services, tobacco cessation and prenatal services.

The nutritious food packages that are provided to the eligible population include for women and children: milk, cheese, eggs, iron-rich cereal, 100% fruit juice, fruits and vegetables, whole grain bread and other whole grain products and beans/peanut butter. Breastfeeding is promoted as the source of the best nutrition for infant but if the mom elects not to breastfeed, the infant receives the following when it is age appropriate: iron-rich infant formula, iron-rich infant cereal and infant fruits and vegetables.

Why do local health departments provide the WIC Program?

- Federal and Kentucky administrative regulations.

Who benefits from WIC?

- Eligible pregnant, breastfeeding and post delivery women, infants and children up to the age five
- Every citizen benefits from a healthier community
- Commonwealth of Kentucky due to savings in Medicaid and health care

Positive health outcomes in our communities because of (WIC):

- Every dollar spent on pregnant women saves $1.92 to $4.21 in Medicaid dollars for newborns and mothers. It costs approximately $601 a year for a pregnant woman to participate in WIC.
- WIC prenatal care benefits reduce the rate of very low birth weight babies by 44%.
- Pregnant women who participate in WIC have:
  - Longer pregnancies
  - Receive earlier prenatal care
  - Have diets higher in iron, protein, calcium and vitamin C
  - Fewer premature births
  - Less low and very low birth weight babies
  - Fewer fetal and infant deaths
  - Access to nutrition and breastfeeding information and education

- Breastfed infants tend to have fewer illnesses
- Children who participate in WIC have:
    - Lower levels of anemia
    - Increased immunization rates
    - Improved access to health care
    - Improved diets
    - Access to nutrition education and information

5. Adult Preventive Services

LHDs provide or arrange for age-appropriate health screenings or services for eligible adults as requested by the individual. Services may include a partial or complete health screening.

The Scope of Adult Preventive Services:

- Comprehensive health history—personal and family health. For example, family history of breast cancer indicates need for closer surveillance of patient.
- Health Risk Assessment—habits and lifestyles which impact health status, for example, domestic violence or poor eating habits
- Comprehensive physical exam—head-to-toe examination
- Routine screening laboratory and diagnostic testing, such as for cholesterol and glucose levels
- Assess immunization status to include TB testing, vaccines for flu and pneumonia, as well as tetanus and diphtheria
- Anticipatory counseling

Methods used by LHDs to perform this service:

- Review of health history
- Teaching patient self-care skills
- Obtaining and interpreting lab tests
- Follow up on abnormal results
- Referral to appropriate resources

Why do LHDs provide Adult Preventive Services?

- Mandated by Kentucky law
- Public demand
- Available access to preventive health care
- Reduced cost of health care—for early detection, costs are less than advanced disease
- Improvement in quality of life for all Kentuckians

Who benefits from Adult Preventive Services?

- Individuals who receive the services
- The entire community

Positive health outcomes in our communities because LHDs provide Adult Preventive Services:

- Early detection of breast and cervical abnormalities and cancers, such as prostate and colon
- Prevention of communicable diseases
- Early detection of diabetes
- Reduction in the number of heart attacks and strokes

6. Chronic Disease Monitoring and Support

LHDs provide screening for certain chronic diseases, such as diabetes and high blood pressure. The LHD also provides follow-up education and support for people with these conditions.

The Scope of Chronic Disease Monitoring and Support

- Assess and monitor chronic disease health status to identify and address problems
- Diagnose and investigate chronic disease health problems and health hazards
- Inform and educate the public and families about chronic disease health issues
- Develop community to identify and solve chronic disease health problems
- Assist the private medical community by monitoring and supporting individuals with chronic diseases

Methods used by LHDs to practice Chronic Disease Monitoring and Support:

- One-on-one counseling and group education classes, presentations, and demonstrations
- Targeted media communication through public health information campaigns
- Community health screenings and one-on-one education at health fairs, churches, community events, and senior citizen's centers
- Community development activities to share resources and promote joint efforts among individuals, support groups, and organizations: schools, churches, clubs, and agencies who share an interest in health
- Individual risk assessments and screenings
- Support research and demonstrations to gain new insights and innovative solutions to health-related problems of people with chronic diseases
- Distribute health information resources and standards of care related to chronic disease

Why do LHDs practice Chronic Disease Monitoring and Support?

- People can be educated and supported so they will take control of their health and thus reduce health care expenditures
- In accordance with Kentucky Law

Who benefits from Chronic Disease Monitoring and Support?

- Children
- Adults
- High-risk populations

Positive health outcomes that regularly occur in our communities because LHDs provide Chronic Disease Monitoring and Support:

- Adults and children engage in healthier lifestyles – engaging in regular exercise, eating healthier foods, and maintaining normal weight
- Adults monitor and control their blood pressure, glucose levels, and cholesterol levels

- The number of new and existing smokers is reduced
- People enjoy an improved quality of life with less disability
- Individuals with diabetes experience a lower incidence of blindness, amputations, and kidney disease
- Fewer people will die prematurely from chronic diseases
- Obesity is reduced in all age groups

Kentucky Revised Statutes (KRS)
For Core Services
For Specific Populations from Appropriated Funds

Enforcement of Public Health Regulations
KRS 258.015, KRS 158.035, KRS 210, KRS Chapter 39A

LHDs enforce public health regulations by providing oversight, education, and assurance of compliance with federal, state, and local public health laws designed to protect and promote the health of the public.

Surveillance of Public Health
KRS 258.015, KRS 258.035, KRS 210

Surveillance is a process of monitoring public health conditions by the ongoing collection, analysis, and sharing of information. The data gained from surveillance is used to develop programs to improve well being and health in the Commonwealth of Kentucky.

Communicable Disease Control
KRS 210.212

Communicable disease control is the process through which LHDs prevent the spread of infectious disease. The key activities include immunizations, investigations and treatment of outbreaks, and public education.

Public Health Education
KRS 211.190, 211.180

LHDs inform and educate individuals, groups, and communities about good health in order to promote healthy lifestyle choices and mitigate health risks.

Public health education also provides critical information that safeguards health and safety response to disaster or other health crises.

Public Health Policy
KRS 211.005, 211.0225, 211.170, 212.210, 212.240

Public health policy encompasses the broad standards and framework that govern a community's public health activities. Policies are based on data from surveillance and the public's directives, usually from public officials, based on that information. Policies are often initiated at the national level but defined and refined to meet needs identified at the state and local levels.

Families and Children Risk Reduction
KRS 211.180

LHDs reduce health risks and problems in the community by identifying and providing needed services or referring individuals to other appropriate providers.

Disaster Preparedness
KRS Chapter 39A

In collaboration with other disaster and emergency service providers, LHDs develop and maintain policies and procedures for responding to disasters. While communities may never actually experience a disaster, some level of preparation is required.

Kentucky Revised Statutes (KRS)
For Preventive Services
For Specific Populations from Appropriated Funds

Family Planning
KRS 211.280, 214.185, 211.090, 211.180

LHDs provide family planning services that consist of educational, medical, and social services to help individuals voluntarily determine the number and spacing of their pregnancies and children.

Prenatal Care
KRS 211.180

LHDs provide prenatal care prior to pregnancy, during pregnancy, and for six weeks after pregnancy to promote the physical and mental well being of the pregnant woman and her infant and family.

Well Child Care
KRS 211.180

LHDs provide a series of preventive health check-ups for children from birth through 20 years of age who are not receiving well childcare from another health provider.

WIC
Federal Regulation-7 CFR Part 256; Section 17 of the Child Nutrition Act of 1966; Administrative Regulation-902 KAR 4:040

LHDs provide nutrition education and healthy foods for pregnant, breastfeeding, and post delivery women, as well as infants and children who meet income and health risk guidelines.

Adult Preventive Services
KRS 211.180

LHDs provide or arrange for age-appropriate health screenings or services for eligible adults as requested by the individual. Services may include a partial or complete health screening.

Chronic Disease Monitoring and Support
KRS 211.180

LHDs provide screening for certain chronic diseases, such as diabetes and high blood pressure. The LHD also provides follow-up education and support for people with these conditions.

Organizational Competencies for Providing Essential Services

Competencies is a term used to signify specific abilities, skills, talents, knowledge, and understanding that are components of individual behavior. Competency is the quality of being functionally adequate in performing activities and assuming that role of a specified position with the requisite knowledge, ability, capability, skill, judgment, attitudes, and values.

The competent public health professional applies the basic public health sciences including behavioral and social sciences, biostatistics, epidemiology, environmental, public health education, and prevention of chronic and infectious diseases and injuries when providing the TEN ESSENTIAL SERVICES.

1. Analytic Skills
2. Communication Skills-Oral and Written
3. Policy and Development/Program Planning Skills
4. Basic Public Health Science Skills
5. Risk Assessment and Risk Communication Skills
6. Knowledge and use of software packages such as Epi-Info
7. Understanding of surveillance systems, survey development and administration, and vital statistics
8. Demonstrates ethical conduct
9. Ability to function in diverse settings and assess cross-cultural relations
10. Collaboration with nontraditional public health providers
11. Demonstration of public relation skills
12. Knowledge of legal and regulatory information
13. Knowledge of primary, secondary, and tertiary prevention for individuals and community
14. Cultural Skills
15. Ability to translate education information into compelling sound “bites”
16. Leadership and Group Development Skills
17. Ability to use the legal and political system to effect change
18. Knowledge of contemporary learning techniques and different theories on education and learning
19. Awareness and understanding of existing networks of consultants, and technical assistants in the community
20. Financial Planning and Management Skills
21. Skill in the utilization and integration of strategic planning process
22. Cost Analysis Skills (cost-effectiveness, cost-benefit, and cost-utility)
23. Collaboration with other public agencies responsible for compliance and inspection
24. Understands risk assessment and health risk assessment
25. Identifies health needs of special and vulnerable populations
26. Coordinates public health and medicine for optimal care
27. Provides or ensures provision of personal health services
28. Prepares or implements emergency response and recovery plan
29. Conduct research across multiple disciplines
30. Seek opportunities and financial resources to investigate approaches to health problems

* Modified from “The Public Health Workforce: An Agenda for the 21st Century”

Community Assessments

Public health services are population-focused – that is, services that are focused on improving the health status of the population, as opposed to the treatment of individuals. To accomplish this public LHDs balance three core public health functions. These functions are essential to the maintenance of population-based services:

1. **Assessment**
2. **Policy Development**
3. **Assurance**

COMMUNITY ASSESSMENTS ARE USED TO:

1. Collect and analyze information about communities, families and individuals.
2. Gain knowledge on current and emerging health issues.

CORE HEALTH FUNCTIONS

First, public LHDs **assess** community health status and whether the community has adequate resources to address the problems that are identified. Second, they must use the status gathered through assessment to **develop health policy** and recommend programs to carry out those health policies. Finally, they must **assure** that necessary, high quality, effective services are available. This includes a responsibility for quality assurance through licensing and other mechanisms.

The first step to start community assessment is to develop **community coalitions.** A coalition is a union of people and organizations working together to influence outcomes on a specific problem.

COALITIONS CONSIST OF:

- Local Health Professionals
- Educators, Head Start Programs
- Social Services Agencies
- Police departments
- Voluntary Agencies
- Hospitals
- Major Employers, Factories, Banks, Health Clubs
- Chambers of Commerce, Community Organizers
- Colleges, Universities
- Highway Department
- Community Leaders, Ministers
- Local Citizens, and others
- See List for “Potential Community Partners” for other resources

Coalitions are useful for accomplishing many goals from information sharing to coordination of services, from community education to advocacy for policy changes. Participation of

different community members is important to provide more insights and provides a broader network of people to be involved.

Advantages of Coalitions:

- Reach more people in a community than a single organization
- Conserve resources
- Accomplish objectives beyond a single organization
- Provide greater credibility than individual organizations
- Reduce suspicion of self-interest
- Provide a forum for sharing information
- Foster cooperation among organizations and community members

Section three in the Community Health Education and Promotional Manual discusses the steps and provides practical advice on how to do Community Assessment and Coalition building. It gives detailed information on the eight steps for coalition building.

Eight Steps for Coalition Building:

1. Devise a set of preliminary objectives and activities for the coalition.
2. Analyze the program's objectives.
3. Recruit the right people.
4. Anticipate the necessary resources.
5. Convene the coalition.
6. Define elements of successful coalition structure.
7. Make improvements through evaluation.
8. Maintain coalition vitality.

EXPLANATION OF CORE HEALTH FUNCTIONS

FIRST CORE HEALTH FUNCTION:

ASSESSMENT – the regular collection, analysis and sharing of information about health conditions, risks and resources in a community.

- Identify trends in illness, injury, and death and the factors, which may cause these events.
- Identify available resources and their application
- Identify unmet needs
- Identify community perceptions about health issues.
- Collect data regarding specific populations.
- Identify at risk and high-risk populations, i.e., frail elderly, unemployed/underemployed people, women without prenatal care, troubled teens, children behind on immunizations, low birth weight
- Assess nutritional trends/needs; housing, jobs, healthcare providers, social services, etc.
- Monitor changing community needs
- Assess changing population trends

Questions to be addressed include:

- What are the major health problems?
- What population groups are at risk?
- How are risks distributed geographically?
- What services are available?
- What is the quality of available services?
- Are health resources adequate?
- What do citizens perceive to be health concerns?
- What do providers perceive to be community health issues?

EXAMPLES OF DATA SOURCES FOR DOING AN ASSESSMENT:

PERSONAL HEALTH DATA

- Vital statistics
- Epidemiology – surveillance, disease reporting & investigation
- Health screening
- Special disease registries
- Laboratory test data
- Hospital discharge data
- Research
- Behavioral Risk Factor Surveys
- Patient Services Reporting System of LHD
- Kentucky Health Interview and Examinations Survey (KHIES)

ENVIRONMENTAL HEALTH DATA

- Sanitary surveys
- Air & water monitoring
- Facility inspections
- Laboratory test data
- Research

DATA ABOUT COMMUNITY CONCERNS AND RESOURCES

- Health resource inventory
- Public forums
- Polling
- APEX, PATCH, Community Education and Promotion Manual
- Information from private & non-profit providers including LHDs
- Research

DATA ON THE RANGE & QUALITY OF SERVICES:

- Selected treatment management review data
- Consumer complaint follow-up information
- Facility and professional licensure data
- Research

OTHER DATA SOURCES

- *Kentucky County Health Profiles*, Kentucky DPH, Health Data Branch, 502-564-2757
- Area Development Districts
- Chamber of Commerce
- Kentucky State Data Center, 502-852-7990
- Local Law Enforcement Agencies
- Division of Disability Determination, 502-564-2818
- DPH, Health Policy Development Branch (hospital data), 502-564-9592
- *Kentucky Health Interview and Examination Survey and Health Behavior Trend: Kentucky Lifestyles,* DPH, Surveillance and Investigation Branch, 502-564-3418
- *Department of Education Youth Risk Behavior Survey,* 502-564-3791
- Local facility inspections and environmental monitoring
- Local polling, interviews, public forums
- Telephone book
- Local resource directories are available in many communities – check with local Chamber of Commerce and Area Development District
- *Guide to Kentucky Public Health Surveillance Systems,* DPH, Surveillance and Investigation Branch, 502-564-3418
- Pediatric Nutrition Surveillance System (PedNSS) – DPH, Nutrition Services Branch, 502-564-3827

Methods of distribution of findings

- Annual vital statistics reports
- Special project reports
- State behavioral risks report
- Professional publications
- Media releases

LHD will collect local data needed for their own services. Along with data, they will assess local citizen's perceptions of their community health status, or what people believe to be the most important health issues facing their community. LHD hold public forums, conduct polls, collect information from private and non-profit providers, as well as, their own population, and engage in research.

SECOND CORE HEALTH FUNCTION:

POLICY DEVELOPMENT – information gathered from assessment used to develop local policies.

It includes:

- Consideration of political, organizational and community values.
- Information sharing, citizen participation, compromise and consensus building.

Process

THE POLICY DEVELOPMENT PROCESS USES:

- Scientific information
- Data from the assessment process
- Information from concerned citizens and providers
- Community values
- An open process, involving all private and public sectors by communicating, networking, and building constituencies

THE POLICY DEVELOPMENT PROCESS:

- Defines health needs.
- Sets priority health issues by analyzing the assessment data.
- Develops policies and plans to address the most important health needs by setting goals and objectives with measurable outcomes.
- Develops alternative strategies for implementing plans.
- Identifies necessary and available resources.

Method

- Develop a plan to address health concerns.
- Develop policies that assure adequate services for the community.
- Recommend policies and programs for target populations.
- Develop education programs for populations, examples: jails, homeless centers, work sites, retirement centers, childcare centers, etc.
- Develop shared ownership of the policy decisions.
- Set priorities, goals and objectives.
- Advocate for target populations who cannot speak for themselves.

LHDs should provide a leadership role in developing local priorities and plans in partnership with the entire community. The strongest public health policy is developed and owned by citizens at the local level.

THIRD CORE HEALTH FUNCTION:

ASSURANCE – making sure that needed health services and functions are available.

THE ASSURANCE FUNCTION CALLS UPON PUBLIC HEALTH AGENCIES TO:

- Provide or assure the availability of public health nursing services.
- Provide or assure the availability of public health nutrition services.
- Provide or assure the availability of environmental health services.
- Encourage, collaborate, purchase or provide additional population-based services.
- Provide personal preventive services through private and public providers.
    - Facilitate coordination of services
    - Improve access to care for individuals and families.
    - Include health promotion and education programs, comprehensive school health education, public education campaigns, professional providers education, day care sites education, and work site health promotion.
    - Coordinate and guide the participation of public and private organizations in prevention programs.
- Maintain emergency response capacity.
    - Disease outbreaks
    - Toxic spills
    - Food and pharmaceutical recall
    - Emergency systems
    - Natural disasters
- Administer quality assurance.
- Help recruit and retain health care providers and practitioners.
- Assist local medical care systems and other local organizations.
- Maintain administrative capacity.
    - Personnel
    - Contracting
    - Budgeting and Accounting
    - Legal counsel

Population-focused health services have saved millions of lives and resulted in the elimination of a number of infectious diseases in this country. Population-focused services focus on the identification of health threats, community health protection, screening and prevention services, health promotion programs and services that improve access to care. Population-focused services are a major contributor to the overall improvement of health status.

CORE FUNCTION CHECKLIST

Steps for community assessment and suggested ways to implement them: Check off as you complete each area – some areas may not apply for your community.

1. **Establish community partnerships.**
    - Send out invitations. Include a fact sheet and contact number.
    - Make phone calls.
    - Send information packets.
    - Build a coalition. – See chapter 3 in *Community Health Education and Promotion Manual* for complete instructions. This coalition should include members from all sectors of the community.
    - Identify the key benefits of public health for all people and all stakeholders.

2. **Assessment of the Community –** Resources to use: *APEX, PATCH, Community Health Education and Promotion Manual, Moving to the Future: Developing Community-Based Nutrition Services*

    A. Collect data.
    - Community wide survey [1,2]
    - Community leaders survey [1,2]
    - Government documents, reports, statistics
    - Census data – from Vital Statistics
    - Maps
    - Local interest and events
    - Personal interviews with local citizens

    B. Develop a Community Health Profile using:
    - Basic demographic information.
    - Data from the Bureau of Census.
    - Health Behavior Trends.
    - Kentucky County Health Profiles from the Center for Health Statistics.
    - Morbidity data.
    - Hospital discharge data.
    - Survey data.
    - Data from Pediatric Nutrition Surveillance System (PedNSS)

    C. Conduct the Community Assessment
    - List assets
    - Determine health risk variables
    - Identify personal health data
    - Identify environmental health data
    - Identify data about community concerns and resources
    - Conduct inventory of primary care services and community services
    - Identify resources and barriers within the local community
    - Identify population trends, at risk and high-risk populations
    - Identify birth and birth-related information
    - Identify community organizations
    - Identify age-adjusted death rates
    - Identify socioeconomic data
    - Determine population variables

- Identify ways to increase productivity of existing resources, i.e., American Cancer Society, American Heart Association, Parent Teacher Organization Groups, hospitals, banks, major employers, etc.
- Identify areas of unnecessary overlap and duplication, outdated or unnecessary programs, procedures, and regulations
- Identify resources needed to meet the health needs of the population

3. **Policy Development**
    - Develop policies that prevent, or support response to community health threats or emergencies
    - Identify what would impact the largest number of people and produce the highest quality of health improvement
    - Formulate realistic outcomes consistent with the database diagnoses – the outcomes should be community focused, stated as relevant goals with measurable objectives, and accompanied by a projected date of accomplishment
    - Plan, organize, and direct public health services and programs aimed at meeting the need of identified populations
    - Develop a plan of care that prescribes interventions to attain expected outcomes
    - Develop policies based on community's findings and coalitions recommendations
    - Develop print media and information packets
    - Solicit support from consumers, local, state, and national health professional groups, and private partners to support public health in Kentucky
    - Develop tools for evaluation of trainings
    - Identify talents and abilities of staff to do core public health functions
4. **Assurance**
    - Mobilize the community to carry out selected interventions to raise health levels
    - Assist and collaborate with other disciplines, allied health, and lay workers to promote access to needed health care services
    - Participate in furthering the education of nurses who need public health skills and continuing education
    - Offer cost-effective services
    - Implement the interventions identified in the plan of care
    - Evaluate progress toward attainment of goals
    - Integrate the skills and knowledge relevant to both nursing and public health
    - Train public health staff in grant writing and planning
    - Increase visibility and awareness of public health activities
    - Develop a speakers' bureau to provide information, education, and programs to schools, civic groups, etc.

[1] Community Health Education and Promotion Manual
[2] Moving to the Future: Developing Community-Based Nutrition Service

REFERENCES

Community Health Education and Promotion Manual – Aspen Reference Group

Core Functions of Public Health: Institute of Medicine (IOM) Report on The Future of Public Health

Minnesota Department of Health State Community Health Services Advisory Committee Publication on "Assessment, Policy Development, and Assurance"

Minnesota Public Health Nursing Directors Publication "Public Health Nursing Core Functions"

Organizational competencies for Providing Ten Essential Public Health Services: Adopted from The Public Health Workforce: An Agenda For The 21st Century, published by the Competency-Based Curriculum Workgroup of the Subcommittee on Public Health Workforce, Training, and Education. Some competencies have been modified.

Ten Essential Services: Essential Public Health Services Workgroup of the Core Public Health Functions Steering Committee (APHA, ASTHO, NACCHO, ASPH, PHF, NASADAD, NASHPD, USPHS), Fall 1994

Washington State National Association of County Health Officials Publication "Core Public Health Functions"

Outcome Measures/Performance Measures/ Objectives for Population Focused Services

These Outcome Measures and Objectives are available for LHD to use for developing a plan to improve health status and to prevent premature death and disability in their community.

The Goals of these Measures and Objectives are:

1. To increase the span of a healthy life
2. To reduce health disparities among the disadvantaged
3. To emphasize preventive health services

These Measures and Objectives benefit the disadvantaged of our state and they emphasize special opportunities for intervention at the community level. They have an emphasis on preventive health activities, lifestyle modification, opportunities and recommendations designed to help the people of Kentucky improve their health and avoid premature death.

http://www.healthypeople.gov/
http://www.chfs.ky.gov/dph/hk2010.htm

National Performance Measures

1. The percent of positive screened newborns who received timely follow-up to definitive diagnosis and clinical management for conditions mandated by their State sponsored newborn screening programs.
7. Percent of 19-35 months who have received full schedule of age appropriate immunizations for Measles, Mumps, Rubella Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.
8. The rate of births (per 1,000) for teenagers aged 15 through 17 years.
9. Percent of third grade children who have received protective sealants on at least one permanent molar tooth.
10. The rate of deaths to children aged 14 and younger caused by motor vehicle crashes per 100,000 children.
11. Percentage of mothers who breastfeed their infants at 6 months of age.
12. Percentage of newborns who have been screened for hearing impairment before hospital discharge.
13. Percent of children without health insurance.
14. Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.
15. Percentage of women who smoke in the last 3 months of pregnancy.
16. The rate (per 100,000) of suicide deaths among youths ages 15-19.
17. Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.
18. Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

State Performance Measures

1. Decrease the death rate for children age 1-18 due to unintentional injury and/or violence.
2. Reduce the rate of substantiated incidence of child abuse, neglect or dependency.
3. The number of Medicaid covered pregnant women who received at least one denial visit during their pregnancy.
4. Increase the percent of women of child bearing age that present to a local health department that receive a pre-conceptual service.
5. Reduce the percentage of live births that are preterm.

National Health Outcome Measures

1. The infant mortality rate per 1,000 live births.
2. The ratio of the black infant mortality rate of the white infant mortality rate.
3. The neonatal mortality rate per 1,000 live births.
4. The postneonatal mortality rate per 1,000 live births.
5. The perinatal mortality rate per 1,000 live births plus fetal deaths.
6. The child death rate per 100,000 children aged 1-14.

Community Health Assessment and Planning
Models/Methods Being Used in Kentucky

Model/Resource Manual	Contact
Assessment Protocol for Excellence in Public Health (APEX-PH)	PQI Division (502) 564-7996
Community Health: Education and Promotion Manual	PQI Division (502) 564-7996
Diabetes Today	PQI Division (502) 564-7996
Community Initiated Decision Making (CIDM)	UK Center for Rural Health Hazard, (859) 439-3557
Planned Approach to Community Health (PATCH)	PQI Division (502) 564-7996
Protocol for Assessing Community Excellence and Environmental Health (PACE-Pilot model being Tested in 10 sites in the country with 2 sites in KY, Developed by NACHO)	N. KY Indep. DHD (859) 341-4264 Barren River DHD (502) 781-8039
Surveillance, Assessment, Planning, Outcomes (SAPO) This is not a formal model, but is an approach being developed by the Barren River District to meet their specific needs	Barren River DHD (502) 781-8039
Community assessments have been initiated by some ADD's, use of a particular model has not been identified	Area Development Districts
Suggested Guidelines for Development of an Epidemiological Profile for HIV Prevention Community Planning Moving to the Future: Developing Community Based Nutrition Services	Prevention Coordinator (502) 564-6539 Nutrition Services Branch (502) 564-2339

COST CENTERS	CODES	FY2011 OBJECTIVES/GOALS
722	241--	24.1 Asthma Education
735	241--	24.2 COPD
736	OHC--	OHC Healthy Communities
801	2208-	22.8 Decrease pneumococcal infections in persons aged 65 & older
801	2210-	22.1 Increase immunization coverage among children19-35 months
801	2212-	22.12 Decrease number of influenza infections in persons 65 & older
804	020WO	020WO WIC Outreach
805	021--	2.1 Healthy wieight for adults, children and adolescents
805	025--	2.5 Five A Day
805	029--	2.9 Dietary Quality
806	2207-	22.7 Reduce incidence of TB
807	251--	25.1 Reduce STD infection rate
813	1CA--	1CA Public education and awareness
813	2CA--	2CA Physician education and awareness
813	3CA--	3CA Training (CA = KY Women's Cancer Screening Program, KWCSP)
813	4CA--	4CA Breast and cervical cancer screening event
813	5CA--	5CA Evaluation
818	0403-	4,3 School health education
818	0505-	5.5 Educate the public and eliminate risk of lead exposure
818	0701-	7.1 Reduce head injuries and deaths
818	0702-	7.2 Reduce spinal cord injuries and deaths
818	0703-	7.3 Reduce firearm injuries and deaths
818	0704-	7.4 Local Child Fatality Review (CFR) Team
818	0705-	7.5 Reduce injuries and deaths due to poisoning
818	0706-	7.6 Reduce suffocation related injuries and deaths
818	0710-	7.10 Reduce transport crash injuries and deaths
818	0715-	7.15 Reduce fire related injuries and deaths
818	0717-	7.17 Reduce drowning
818	0720-	7.20 Reduce violence related injuries and deaths
818	091--	9.1 Dental caries
818	093--	9.3 Reduction and replacement of tooth loss
818	095--	9.5 Oral cancer
818	097--	9.7 Optimal water fluoridation
818	099--	9.9 Oral health partnerships
818	101--	10.10 Reduce the number of people without healthcare coverage
818	105--	10.5 Increase training to health care clinicians
818	106--	10.6 Increase the percent of people who have ongoing primary care
818	111--	11.1 Increase knowledge and use of family planning services
818	112--	11.2 Reduce adolescent pregnancy
818	1212-	12.12 Decrease percent of low birth weight live births and premature births
818	1215-	12.15 Increase the percentage of mothers whom initiate breastfeeding, and; …
818	1216-	12.16 Reduce the incidence of Neural Tube Defects (spina bifida & anencephaly)
818	1221-	12.21 Increase the number of educational activities related to newborn screening
818	1702-	17.2 Lung cancer death rate
818	1707-	17.7 Colorectal cancer deaths
818	1708-	17.8 Fecal occult blood testing (FOBT) and sigmoidoscopy/colonoscopy
818	1709-	17.9 Prostate cancer screening

COST CENTERS	CODES	FY2011 OBJECTIVES/GOALS
818	1710-	17.10 Oral and skin cancer screening
818	231--	23.1 Children's social/emotional health
818	1SA--	SA1 Reduce substance abuse (SA = Chapter 26 Substance Abuse)
818	2SA--	SA2 Reduce substance abuse in pregnant women
818	3SA--	SA3 Decrease suicide attempts in adolescents related to substance abuse
818	0708-	7.8 Reduce unintentional injuries and deaths
830	1CA-C	1CA Public education and awareness
830	2CA-C	2CA Physician education and awareness
830	3AC-C	3CA Training (CA = KY Women's Cancer Screening Program, KWCSP)
830	4AC-C	4CA Breast and cervical cancer screening event
830	5AC-C	5CA Evaluation
832	201--	20.1 Reduce heart disease deaths
832	202--	20.2 Reduce stroke deaths
832	203--	20.3 Decrease high blood pressure
832	204--	20.4 Increase blood cholesterol check
832	205--	20.5 Increase awareness of heart attack
832	207--	20.7 Increase awareness of stroke
833	1215G	12.15G Increase the percentage of mother who continue duration of breastfeeing
843	210--	21.0 HIV
843	212--	21.2 Reduce HIV infection
843	214--	21.4 Prevent HIV transmission
843	219--	21.9 Increase classroom education on HIV and STD
856	1601C	16.1C Arthritis Community
856	1601G	16.1G Arthritis Grant
856	1612O	16.12O Osteoporosis
857	012--	01.2 Adult physical activity
857	014--	01.4 Child and adolescent physical activity
883	120EO	120EO EPSDT Outreach
890	100VS	100VS Vital Statistics/Local Registrar activities
890	140--	14.0 Community Assessment/Public Health infrastructure
890	141--	14.1 Public health competencies/Public Health infrastructure
890	1412-	14.12 Facilitate Greater collaboration/Public Health infrastructure
890	143--	14.3 Continuing education & training - Public Health infrastructure
890	147--	14.7 Measure HK 2010 Objectives/Public Health infrastructure

COST CENTER	ACTIVITY/ OBJECTIVE CODE	DESCRIPTION	STRATEGY	DESCRIPTION
722	24.1	Asthma Education	127	Certified Asthma Educator Workshop/Exam
			130	Public Awareness Campaign
			131	Asthma Community Forum
			223	Asthma Education: Curriculum for school-aged children
			224	Asthma 1-2-3
			225	Asthma Toolkit
735	24.1	COPD	225	Education and Public Awareness
736	OHC	Healthy Communities	01	Complete Healthy Communities Readiness Tool by September 20, 2010 (Required)
			02	Develop Healthy Communities Leadership Team by September 20, 2010 (Required)
			03	Secure Letters of Commitment from five (5) specific community agencies and/or organizations by September 30, 2010 (Required)
			04	Develop on-going Healthy Communities Coalitions (Required; see instructions)
			05	WALKABILITY ASSESSMENT (Required by October 30, 2010)
			06	CHANGE TOOL (Required by March 30, 2011)
			07	Healthy Communities Conference (Required, May 2011)
			20	Promote increased physical activity
			21	Promote active transportation (bicycling and walking for communities and leisure activities)
			22	Counter-advertising for screen time
			23	Safe, attractive assessable places for activity (Access to outdoor recreation facilities, enhanced bicycling, and walking in)
			24	City Planning, zoning and transportation
			25	Require Daily Quality P.E. in Schools
			26	Require Daily PA in Afterschool/Childcare Settings
			27	Restrict Screen Time (Afterschool, Daycare)
			28	Signage for neighborhood destinations in walkable/mixed-used areas
			29	Signage for Bike Lanes
			30	Reduced price for park/facility use
			31	Incentives for active transit
			32	Subsidized memberships for recreational facilities
			33	Safe Routes to School
			34	Workplace, faith, park, neighborhood activity groups (Walking, hiking, biking)
			35	Media and advertising restrictions consistent with federal law
			36	Promote healthy food/drink choices
			37	Counter-advertising for unhealthy choices
			50	Increase Healthy food/drink availability
			51	Limit unhealthy food/drink availability
			52	Reduce density of fast food establishments
			53	Eliminate transfer through purchasing actions, labeling initiatives, restaurant standards
			54	Reduce sodium through purchasing actions, labeling initiatives, restaurant standards
			55	Procurement policies and practices
			56	Farm to institution, including schools, worksites, hospitals, and other community institutions
			57	Signage for healthy vs. less healthy items
			58	Improve Product placement & attractiveness
			59	Menu labeling
			60	Decrease the consumption of sweetened beverages

COST CENTER	ACTIVITY/ OBJECTIVE CODE	DESCRIPTION	STRATEGY	DESCRIPTION
			61	Changing relative prices of healthy vs. unhealthy items
			62	Support breastfeeding through policy change and maternity care practices
			70	Paid or earned Media
			71	Usage bans (100% smoke-free policies or 100% tobacco-free policies)
801	22.8	Decrease pneumococcal infections in persons aged 65 & older	101	Develop community-based coalitions
			102	Provide media updates
			103	Provide immunization information for all age groups
			104	Establish new/strengthen existing partnerships
	22.1	Increase immunizations coverage among children 19-35 months	11	Provide immunization information for all age groups
			12	Provide media with updates
			14	Develop community-based coalitions
			15	Establish new/strengthen existing partnerships
	22.12	Decrease number of influenza infections in persons 65 & older	107	Develop community-based coalitions
			108	Establish new/strengthen existing partnerships
			109	Provide immunization information for all age groups
			110	Provide media with updates
			111	Develop community-based coalitions
804	020WO	WIC Outreach	01	Outreach
805	2.1	Healthy weight for adults, children and adolescents	69	Fruits and Veggies: More Matters®
			70	Choose 1% or Less
			72	Wellness Winners
			77	Health Fairs
			78	Eat Smart Play Hard
			79	Healthy choices at Restaurants
			80	Milk vending machines
			81	Healthy choices in school vending machines
			104	Physical Activity Nutrition and Tobacco (PANT) (KDE) Units of Study
			201	My Pyramid/My Pyramid for Kids
			202	Grocery Store Tours
			207	Weight the reality series
			208	Star Chef Curriculum
			214	We CAN!
			215	Fit WIC Kit activities
	2.5	Five-A-Day	82	Fruits and Veggies: More Matters®
			210	Star Chef Curriculum
			216	We CAN!
	2.9	Dietary Quality	91	Fruits and Veggies: More Matters®
			92	Choose 1% or Less
			95	Wellness Winners
			100	Eat Smart Play Hard
			203	My Pyramid/My Pyramid for Kids
			204	Physical Activity Nutrition and Tobacco (PANT) (KDE) Units of Study
			213	Star Chef Curriculum
			217	We CAN!
806	22.7	Reduce incidence of TB	01	Provide TB in-services to 90% of local nursing homes or assisted-living communities

COST CENTER	ACTIVITY/ OBJECTIVE CODE	DESCRIPTION	STRATEGY	DESCRIPTION
			02	Collaborate with hospital/infection control staff to coordinate prevention activities and reporting strategies
			03	Provide TB education to the community once per quarter
			04	Provide TB education targeted toward transient population twice per year
			05	Provide TB education targeted toward foreign-born populations twice per year
807	25.1	Reduce STD infection rate	01	Education/information, targeted toward at-risk populations
			02	Screening targeted toward at-risk populations
			03	Provider education re: screening, diagnosis, treatment and prevention of complications
813	1CA	Public education and awareness	01	Media
			02	Development, Distribution, and Reproduction of Educational Material
			03	Educational Presentations
	2CA	Physician education and awareness	04	Distribution of Educational Material
			05	Educational Presentations
	3CA	Training (CA=KY Women's Cancer Screening Program, KWCSP)	06	KWCSP Training
			07	Other Breast and Cervical Cancer or Outreach-Related Training
	4CA	Breast and cervical cancer screening event	08	Breast/Cervical Cancer Screening Event
	5CA	Evaluation	09	Community Reporting Form
818	4.3	School health education	500	School Health Education Other
	5.5	Educate the public and eliminate risk of lead exposure	02	Handouts/brochures
			03	Community health fairs
			04	Community baby showers
			05	Agency newsletters
			06	In-service training for local health department staff
			07	Mass media campaigns
			08	In-service training for local private health providers
	7.1	Reduce head injuries and deaths	09	Public Education
			13	Safe Sitter Program
			15	Safety Seat Use
			16	Restraint/Seatbelt Use
			17	Helmet Use (bicycling, skateboarding)
	7.2	Reduce spinal cord injuries and deaths	18	Public Education
			19	Safety Seat Use
			20	Restraint/Seatbelt Use
			21	Helmet Use (bicycling, skateboarding)
	7.3	Reduce firearm injuries and deaths	350	Public Education
	7.4	Local Child Fatality Review (CFR) Team	11	Local CFR Team
	7.5	Reduce injuries and deaths due to poisoning	23	Public Education
	7.6	Reduce suffocation related injuries and deaths	24	Public Education

COST CENTER	ACTIVITY/ OBJECTIVE CODE	DESCRIPTION	STRATEGY	DESCRIPTION
			25	Safe Sitter Program
			200	Back to sleep
			201	Infant safe sleeping environment
	7.10	Reduce transport crash injuries and deaths	27	Public Education
			28	Safety Seat Use
			29	Restraint/Seatbelt use
			30	Helmet use (bicycling, skateboarding)
	7.15	Reduce fire related injuries and deaths	31	Public Education
			32	Safe Sitter Program
	7.17	Reduce drowning	22	Public Education (water safety)
	7.20	Reduce violence related injuries and deaths	33	Public Education
	9.1	Dental caries	25	Improve the awareness of an access to sealant services in the community
			26	Improve the awareness of an access to varnish in the community for high risk populations
			27	Increase the number of people obtaining preventive and restorative care regardless of the source of payment for these services, especially for disparate populations
	9.3	Reduction and replacement of tooth loss	28	Provide oral health education programs and materials focusing on the importance of retention and replacement of natural dentition
			29	Provide oral health education about the relationship between periodontal disease and chronic diseases such as diabetes, cardiovascular disease and prenatal conditions
			30	Increase the number of people obtaining preventive and restorative care regardless of the source of payment for these services, especially for children
			31	Provide oral health education, facilitate screening and treatment in long-term care and mental health facilities
	9.5	Oral cancer	32	Provide oral cancer awareness campaign and screening and education program
			33	Provide oral health education as to the impact of tobacco use and oral cancers
	9.7	Optimal water fluoridation	34	Provide education about the importance of optimal fluoride levels in regards to good oral health
			35	Provide information about infant feeding practices regarding preparation of formula with fluoridated water or fluoridation supplementation
	9.9	Oral health partnerships	36	Provide oral health education and materials to partners regarding specific populations such as the elderly, low- income individual and ethnic minorities
			37	Collaborate with dental organizations to arrange screening opportunities
			38	Provide oral health education and materials regarding oral and periodontal health for high-risk pregnant women
	10.1	Reduce the number of people without healthcare coverage	53	Promote and educate Kentucky's citizens regarding the Kentucky Physicians Care Program

COST CENTER	ACTIVITY/ OBJECTIVE CODE	DESCRIPTION	STRATEGY	DESCRIPTION
			240	Promote and educate Kentucky's citizens regarding the Prescription Assistance Program
	10.5	Increase training to health care clinicians	54	Develop and conduct training to Health Care Professionals
	10.6	Increase the percent of people who have ongoing primary care	57	Promote and educate Kentucky citizens regarding the services provided by the local health department
			58	Develop and conduct local community primary care needs assessments through community mobilization
	11.1	Increase knowledge and use of family planning services	59	Mass media campaign
			60	Partner with pharmaceutical companies
			61	Partner with school systems
			63	Identify new partners in the communities
			64	Develop an educational campaign
			65	List hours of service
			66	List emergency 24hour telephone numbers
			67	List confidentiality policy
			68	List counseling services
			69	Contact local politicians
			70	Contact local school boards
			71	Present family planning issues at club meetings
			72	Contact media to publish all services offered
			73	Guest speakers
			74	Local physicians
			75	Medical Director
			76	Nurse Practitioners
			77	Private area for brown bag pick up
			78	Provide privacy for supply pick up
			79	Post Title X services offered
			80	Confidential adolescent services
			146	Post emergency telephone numbers
			304	Information & Education/Community Participation Committee
			305	Parental Involvement Workshops "Beyond Birds & Bees"
	11.2	Reduce adolescent pregnancy	81	Community Work-Groups and Coalitions
			83	Postponing Sexual Involvement/Managing Pressures before Marriage Curriculum (Preteen, Young Teen, Teen Series)
			84	Teen Outreach Program (TOP)
			306	Kentucky Teen Pregnancy Coalition
			307	Youth Councils on teen pregnancy prevention
			308	Mass Media Campaign
			309	Community Awareness Events
			310	After School Program
			311	Service Learning Projects regarding teen pregnancy
			312	Advancing Youth Development Basics Training (offered by Kentucky Child Now)
			313	Heritage Keepers Curriculum
			314	Choosing the Best Curriculum (Way, Life, path, Journey, Soul Mate)
			315	Plain Talk Project (help adults, parents, & community leaders talk to youth about reducing sexual risk taking)
			316	Parent Education Programs

COST CENTER	ACTIVITY/ OBJECTIVE CODE	DESCRIPTION	STRATEGY	DESCRIPTION
	12.12	Decrease percent of low birth weight live births and premature births	86	Prenatal Classes for pregnant women
			87	Substance Abuse Prevention Programs through collaboration with Community Mental Health Programs
			88	Smoking Cessation Program, use of the Quit Line video, and/or utilization of the Fax Referral Form
			89	Media Campaigns, including promotion and utilization of the Healthy Babies are Worth the Wait Prematurity Prevention Toolkit, to promote healthy lifestyles for pregnant women
			92	Improve the oral health of the pregnant women in KY by promoting health fairs, developing partnerships with community dental professionals to assist access to oral care for disparate populations, and to enhance dental care provider's education on the risks and treatments of periodontal disease in pregnancy
			147	Provide educational materials in pregnant women in health care settings, in warning signs about preterm labor
			203	Work in partnership with community obstetrical providers to enhance education latest research data that suggests contributing factors for premature births include periodontal disease, bacterial vaginosis, maternal smoking, and inadequate weight gain
			204	Routine screening for domestic violence and sexual assault to provide education, support and appropriate referrals to community support services to women identified as victims of domestic violence and sexual assault
			205	Enhance the access and provision of preconception and prenatal care in non-traditional sites such as neighborhood community centers which may utilize Healthy Babies are Worth the Wait
			207	Participate in statewide or community initiatives such as the KY Folic Acid Partnership or FIMR to emphasize prematurity prevention activities and to improve perinatal outcomes
	12.15	Increase the percentage of mothers whom initiate breastfeeding, and…	93	Professional education for health care providers: Shape the Future Breastfeed
			94	Breastfeeding coalitions
			95	Development of breastfeeding rooms
			97	Breastfeeding Friendly Worksites
			98	Providing breast pumps to Moms returning to school or work
			99	Rock and Relax booth at KY State Fair, and Portable Mother Nurture Room at Health Fairs and county fairs
			148	Mother to Mother Support Groups
	12.16	Reduce the incidence of Neural Tube Defects (spina bifida & anencephaly)	100	Professional education for health care providers and promote outreach
			101	Media announcements to promote public awareness of the importance of folic acid
			102	Health fairs to promote the daily consumption of a multi-vitamin and foods containing folic acid
	12.21	Increase the number of educational activities related to newborn screening	209	HANDS home visitation
			210	First Step referrals for diagnosed infants
			212	Health fairs

COST CENTER	ACTIVITY/ OBJECTIVE CODE	DESCRIPTION	STRATEGY	DESCRIPTION
			213	Media campaigns promoting healthy choices for pregnant women
			214	Educational packets to share with pregnant women in health care settings
			219	Childbirth education classes
	17.2	Lung cancer death rate	103	Community-wide health education classes (pre-approved)
			104	Projects under Comprehensive Cancer Control Grant (pre-approved)
	17.7	Colorectal cancer deaths	105	Screen for Life
			106	Professional education (pre-approved, see information and resources)
			107	Projects under Comprehensive Cancer Control Grant (pre-approved)
			109	Projects with Kentucky Cancer Consortium (pre-approved)
	17.8	Fecal occult blood testing (FOBT) and sigmoidoscopy/colonoscopy	110	Community-wide health education classes (pre-approved)
			112	Professional education (pre-approved, see information and resources)
			114	Screen for Life or DPH approved materials
			115	Projects with Kentucky Cancer Consortium (pre-approved)
	17.9	Prostate cancer screening	116	Man-to-Man Prostate Cancer Education and Support Program (pre-approved)
			117	Projects under Comprehensive Cancer Program (pre-approved)
	17.10	Oral and skin cancer screening	121	Oral Cancer Awareness Campaign (refer to 9.5)
			122	Choose Your Cover
			123	Projects under Comprehensive Cancer Program (pre-approved) (Refer to 9.5 for additional partnerships for oral cancer screening)
			226	Professional education (pre-approved)
	23.1	Children's social/emotional health	124	Health fairs
			220	Behavioral Change Education
			221	Social-Emotional Screening and Assessment
			322	Health Promotion/Education
	SA1	Reduce substance abuse (SA=Ch. 26 Substance Abuse)	133	Across Ages
			134	Creating Lasting Family Connections (CLFC)
			135	LifeSkills Training (LST)
			137	Project Alert
			138	Project Northland
			139	Reconnecting Youth (RY)
			140	Strengthening Families Programs (SFP)
	SA2	Reduce substance abuse in pregnant women	141	Develop partnerships with local Community Mental Health Centers
	SA3	Decrease suicide attempts in adolescents related to substance abuse	319	Media Campaigns
			320	QPR (Question, Persuade and Refer) Gatekeeper Training
			321	Signs of Suicide (SOS)
			322	Reconnecting Youth (RY)
			323	C-Care/Cast

COST CENTER	ACTIVITY/ OBJECTIVE CODE	DESCRIPTION	STRATEGY	DESCRIPTION
			324	Holding The Life Line
			325	Kentucky Suicide Prevention Group (KSPG)
			326	Local Suicide Prevention Coalitions
			327	Adolescent Survivor Support Groups (postvention)
830	1CA	Public education and awareness	01	Media
			02	Development, Distribution, and Reproduction of Educational Materials
			03	Educational Presentations
	2CA	Physician education and awareness	04	Distribution of Educational Materials
			05	Educational Presentations
	3CA	Training (CA=KY Women's Cancer Screening Program, KWCSP)	06	KWCSP Training
			07	Other Breast and Cervical Cancer or Outreach-Related Training
	4CA	Breast and cervical cancer screening event	08	Breast/Cervical Cancer Screening Event
			09	Facilitation of routine screening activities
	5CA	Evaluation	11	Community Reporting Form
832	20.1	Reduce heart disease deaths	200	Community-wide campaign addressing heart disease & stroke, including early warning signs
			201	Blood Pressure Control
			202	Cholesterol Control
			203	Health risk assessments
			204	Worksites through worksite wellness
			205	Communities through networking coalitions
	20.2	Reduce stroke deaths	10	Community-wide campaigns addressing stroke, including early warning signs
			11	Blood Pressure Control
			12	Cholesterol Control
			206	Health risk assessments
			207	Worksites through worksite wellness
			208	Communities through networking coalitions
	20.3	Decrease high blood pressure	16	Community-wide campaign addressing blood pressure control
			18	Blood Pressure Control
			20	Self-monitoring of blood pressure
			209	Worksites offering blood pressure monitoring
	20.4	Increase blood cholesterol check	210	Community-wide campaign addressing cholesterol control
			211	Cholesterol Control
			212	Know your numbers – cholesterol checks
			213	Worksites offering cholesterol monitoring
	20.5	Increase awareness of heart attack	214	Community-wide campaign addressing early signs of heart attack
			215	Community-wide campaign addressing the importance of calling 9-1-1
			216	Signs and symptoms of a heart attack
			217	Risk factors for a heart attack
			218	Worksites through worksite wellness and educational approaches
	20.7	Increase awareness of stroke	219	Community-wide campaign addressing early warning signs of stroke

COST CENTER	ACTIVITY/ OBJECTIVE CODE	DESCRIPTION	STRATEGY	DESCRIPTION
			220	Community-wide campaign addressing the importance of calling 9-1-1
			221	Signs and symptoms of a stroke
			222	Risk factors for a stroke
			223	Worksites through worksite wellness and educational approaches
833	12.15G	Increase the percentage of mothers who continue duration of breastfeeding	93	Shape the Future Breast-Feed
			94	Breastfeeding coalitions
			95	Development of breastfeeding rooms
			97	Breastfeeding Friendly Worksites
			99	Rock and Relax booth at KY State Fair, and portable Mother Nurture Rooms at local health fairs and county fairs
			148	Mother to Mother Support Groups
			201	Programs for residents, colleges, technical schools, health professional community
			202	Radio, television, newspaper interviews/articles
			203	Health fairs
			204	Billboards
843	21.0	HIV	01	Make information and materials about HIV transmission available
			02	Increase client awareness of at-risk behaviors for HIV transmission through risk assessments
			03	Assist client in developing a personalized HIV Prevention Plan
			04	Provide support including prevention for substantial behavioral change
	21.2	Reduce HIV infection	05	Conduct health education activities for persons at increased risk of becoming infected with HIV
			06	Host workshops and presentations to disseminate important information on HIV/AIDS prevention
	21.4	Prevent HIV transmission	11	Conduct health education activities for HIV+ persons to prevent HIV transmission
	21.9	Increase classroom education on HIV and STD	18	Make professional education available to health care providers and educators
			20	Obtain approval to offer HIV/AIDS professional education within the agency
856	16.1C	Arthritis Community	04	Teach the Arthritis Foundation Self-Help Program
			05	Teach the Arthritis Foundation Exercise Program
			06	Arthritis Educational materials (brochures/fact sheets/posters)
			204	Teach the Arthritis Foundation Aquatic Program
			205	Arthritis Foundation Self-Help Instructor Trainer Course
			206	Arthritis Foundation Aquatic Instructor Trainer Course
			207	Arthritis Foundation Exercise Instructor Trainer Course
			209	The Arthritis Foundation Media Campaign
			301	Chronic Disease Self-Management Program Instructor Trainer Course
			302	Teach the Chronic Disease Self-Management Program
	16.1G	Arthritis Grant	02	Teach the Arthritis Foundation Exercise Program

COST CENTER	ACTIVITY/ OBJECTIVE CODE	DESCRIPTION	STRATEGY	DESCRIPTION
			203	Arthritis Foundation Exercise Instructor Trainer Course
			301	Chronic Disease Self-Management Program Instructor Trainer Course
			302	Teach the Chronic Disease Self-Management Program
	16.12O	Osteoporosis	309	A Matter of Balance Coach Training Course
			310	A Matter of Balance Participant Class
			311	Falls Prevention Community Education and Awareness
			316	Osteoporosis Toolkit
			317	The Strong Women Exercise Program
			318	Tai Chi
			319	Evidence-Based Falls Prevention Programs
			320	Heel Scan/Bone Health Education
857	01.2	Adult physical activity	09	Physical Activity Community Resource Guide
			11	Community Physical Activity Coalition/Partnership for Fit Kentucky
			13	Body Recall
			203	Chronic Disease Self-Management Program
			204	YogaFit
			206	Arthritis Foundation Exercise Program
			309	A Matter of Balance Program
			317	Strong Women Exercise Program
			318	Tai Chi
			320	Physical Activity in Public Health (PAPHS) Certification (up to two certifications per health department with PHHSBG Funds)
	01.4	Child and adolescent physical activity	215	VERB/TWEENS/LONGEST DAY OF PLAY
			218	Take 10
			219	Coordinate School Health Councils/Committees
			221	We Can! Plus
			240	Students Taking Charge
			321	Second Sunday
883	120EO	EPSDT Outreach	Activity 04	Information & Material Distribution
			Activity 07	Community Planning Activities
			Activity 10	EPSDT Face-to-Face
			Activity 11	EPSDT Phone
			Activity 12	EPSDT Home Visit
			Activity 13	EPSDT Letter
			Activity 14	EPSDT Appointment Made
			Activity 15	Mailed/Provided KCHIP Application
			Activity 16	Completed KCHIP Application
			Activity 17	Submitted KCHIP Application
890	100VS	Vital Statistics/Local Registrar activities	28	Registration and filing of births, deaths, and stillbirths
	14.0	Community Assessment/Public health infrastructure	06	MAPP model
	14.1	Public health competencies/Public health infrastructure	08	Determine the current status of “competency” of the Kentucky Public Workforce
			10	Develop measurable performance indicators for the identified competencies
			13	Develop a method of assessing whether the standards are being met

COST CENTER	ACTIVITY/ OBJECTIVE CODE	DESCRIPTION	STRATEGY	DESCRIPTION
	14.12	Facilitate Greater collaboration/ Public health infrastructure	19	Establish formal relationships with private agencies with public health and community interests
			20	Assist private agencies with epidemiologic expertise
	14.3	Continuing education and training /Public health infrastructure	15	Identify the specific competencies by discipline according to the essential services
			16	Target specific disciplines for education and training
	14.7	Measure HK 2010 Objectives/Public health infrastructure	18	Collect and analyze surveillance and vital data on one (1) and three (3) year intervals

The following Programs/Cost Centers are using Community Action on Tobacco evALuation sYSTem (CATALYST) to report their data:

809 Diabetes
821 Preparedness Coordination
822 Epidemiology & Surveillance
823 Medical Reserve Corps
825 Training Coordination
836 Tobacco
841 Diabetes Today Coalition
875 Hospital Preparedness Program
876 Cities Readiness Initiatives

COMMUNITY HEALTH ACTIVITIES REPORTING

PROCEDURES FOR REPORTING COMMUNITY HEALTH SERVICES

A Community Health Services Report (CHSR) CH-48 is completed for each event/activity. The data is to be reported through the PSRS Supplemental-Community Health Services Reporting System. The data should be entered into the system within 15 days of the presentation or meeting.

Once the CHSR form has been entered into the system, a label will be produced with the key identifying information and the system assigned document number. This label should be affixed to the CHSR Form. CHSR forms should be kept on file for six years.

NOTE: Up to six (6) events may be entered on the same CHSR. Therefore there may be six (6) labels affixed to the one CHSR form. If after the document(s) have been entered a change is necessary, the document number must be referenced.

A report (#615), which contains information that has been entered for each of the documents, will run the day following entry of the forms. This report will be considered your audit trail for data entry and should be kept with the input forms.

COMMUNITY HEALTH SERVICES REPORT FORM (CH-48) INSTRUCTIONS

The Community Health Services Report (CH-48) is to be used to report all community-based activities provided with 818 funds as well as the other Cost Centers listed on the back of the report form. The data is to be entered into the system within 15 days of the event/activity. Please note that each event/activity may be reported only once, regardless of the number of providers.

Each health department should contact Local Health Operations at (502) 564-6663 Ext. 3150 to designate a new primary and/or secondary contact for community-based activities if they change during the fiscal year. These people are responsible for ensuring timely and accurate reporting of all community-based activities as well as assuring all health department community-based staff are aware of all communications from the state health department pertaining to community-based activities. Problems with data entry should be forwarded to the Help Desk at (502) 564-6663.

County of Service Code:	Enter the county code for the county in which the event/activity took place.
Lead Provider #:	Enter the provider number of the staff who takes the assigned lead for the event/activity.
Date of Presentation:	Entering six digits, list month, day, year the event/activity occurred.
Place/Type:	Enter the code which identifies the place the event/activity took place or the type of service as it relates to the media. These codes are located on the back of the Community Health Services Report. For EPSDT Only, 14-Private Providers, 15-School System, and 16-Community Events should be used to report number of contacts/events (not participants) with activity codes 01-09. Exception: If a specific number of children are targeted such as with preparing packets for Health Fair for School Orientation, **count number of children as participants**. For EPSDT Only, 17-New Eligibles and 18-Other Than New Eligibles should be used to report number of children with activity codes 10-13.
Cost Center:	Enter the Cost Center for which the event is being conducted. In most cases, this is the Cost Center in which the activities were listed in your community-based activities plan.
Objective/ Program Code:	Enter the code for the 2010 objective/MCH performance measure designated in your community-based activities plan for which this activity is occurring. These objectives/performance measures should match the community-based activities plan except when the activity isn't included in the plan. In which case, choose the most appropriate 2010 objective/MCH performance measure. These codes are located as an attachment to the Community Health Services Report.

Strategy #:	Enter the two or three digit number of the strategy as designated in your community-based activities plan under the column. (Does not apply to Cost Center 883 – EPSDT.)
Activity Code:	Enter the two digit activity code that best reflects the type of event/activity taking place (*example: 01, 02, etc.).* Activity Codes 10-13 are for EPSDT Only and should routinely only be used with Place/Type of Service Codes 17-New Eligibles and 18-Other than New Eligibles. Exception: When activities are actually provided within the school, may be used with 15-Schools. When actually provided within the community, may be used with 16-Community.
Gender:	Enter the number of attendees that were male and the number that were female. These numbers collectively should total the same as the Total Contacts/Participants. This item should not be completed when using activity codes 4, 7, 8 or 9. (This field does not apply to any activity for Cost Centers 883 – EPSDT and 818 Community Objective 7.4 Local Child Fatality Review Team.)
Race:	Enter the number of attendees from the respective groupings as follows: W-White; B-Black; N-American Indian or Alaska Native; A-Asian; H-Native Hawaiian or Other Pacific Islander; and U-Unknown. These numbers collectively should total the same as the Total Contacts/Participants. This item should not be completed when using activity codes 4, 7, 8, or 9. (This field does not apply to any activity for Cost Centers 883 – EPSDT and 818 Community Objective 7.4 Local Child Fatality Review Team.)
Ethnicity:	In addition to Race, enter the total number of attendees who self-declare ethnicity for Hispanic or Latino as "L". Hispanic or Latino is a person of Cuban, Mexican, Puerto Rico, South or Central America, or other Spanish culture or origin, regardless of race. The term "Spanish origin" can be used in addition to "Hispanic or Latino." This item should not be completed when using activity codes 4, 7, 8, or 9. (This field does not apply to any activity for Cost Centers 883 – EPSDT and 818 Community Objective 7.4 Local Child Fatality Review Team.)
Age:	Enter the number of attendees for each appropriate age group. These numbers collectively should total the same as the Total Contacts/Participants. This item should not be completed when using activity codes 4, 7, 8 or 9. (This field does not apply to any activity for Cost Centers 883 – EPSDT and 818 Community Objective 7.4 Local Child Fatality Review Team.)
Total Contacts/ Participants:	Enter the total number of attendees/contacts/participants. When reporting activity codes 01-09 for EPSDT Only, 14-Private Providers, 15-School System and 16-Community Events, report contacts as **number of activities**, **NOT** specific number of participants. Exception: If a specific number of children are targeted such as with preparing packets for Health Fair for School Orientation, count number of children as participants. When reporting activity codes 10-

13 for EPSDT Only, 17-New Eligibles and 18-Other Than New Eligibles, report specific **number of children** outreached.

Contact Time: Enter the time in minutes (15 minute increments) that was spent with the attendees in the actual event/activity. Local use only for EPSDT Outreach.

Prep Time: Enter the time in minutes (15 minute increments) spent in preparing for the event. Include travel and all other time not included in contact time. Local use only for EPSDT Outreach.

Cases: Enter the number of child death cases reviewed during meeting. (This field only applies to Cost Center 818 Community Objective 7.4 Local Child Fatality Review Team).

Agencies: Enter the types of agencies represented at meeting. List the seven main agencies represented. If "Other" is chosen, list the type of agency "Other" represents. (This field only applies to Cost Center 818 Community Objective 7.4 Local Child Fatality Review Team).

Causes: Enter the cause(s) of death based on the child death cases reviewed. If "Other" is chosen, list the causes of death "Other" represents. (This field only applies to Cost Center 818 Community Objective 7.4 Local Child Fatality Review Team).

A Community Services Reporting Form (CH-48EO) is included, but not required, for reporting EPSDT/KCHIP Outreach provided by LHD clinic staff. Instructions for using the form are on the back of the form.

COMMUNITY BASED SERVICE ACTIVITY CODE DEFINITIONS

01 – Health Promotion/Education*
An interactive presentation of general information provided to community groups or other groups of people that is not required to be reported in the Supplemental Reporting System. Report each presentation separately and also report ethnicity, gender, age, and total attendance. Examples of health promotion/education included but are not limited to: nutrition education, family planning education, physical activity education, substance abuse education, and personal hygiene education. *(Not to be used for EPSDT Outreach.)*

02 – Behavior Change Education
An interactive presentation provided to a group of people or individuals to teach a specific curriculum or skill and that is not required to be reported in the Supplemental Reporting System. Report each presentation separately and also report ethnicity, gender, age and total attendance. Examples of behavior change education include but are not limited to: PSI, RTR, Resource Persons Protocols, Diabetes group patient education, prenatal education, Ky. Smile Curriculum and/or demonstrations on brushing and flossing, and Safe Sitter. *(Not to be used for EPSDT Outreach.)*

03 - Professional Education for Health Care Providers and Educators*
An interactive presentation provided to a group of health care providers or educators that is not required to be reported in the Supplemental Reporting System. Report each presentation separately and also report ethnicity, gender, age, and total attendance. Examples include but are not limited to: First Aid/CPR classes, Bloodborne Pathogen classes, Diabetes Awareness sessions, and Smoking Cessation classes. *(Not to be used for EPSDT Outreach.)*

04 – Information and Material Distribution*
A non-interactive activity involving the distribution of educational materials or information that is not required to be reported in the Supplemental Reporting System. Report each activity separately, but do not report ethnicity, gender, age, or total participants. Examples of non-interactive activities include but are not limited to: distribution of brochures, newspaper articles, informational hotlines, and television or radio educational programs. (Use for EPSDT Outreach when materials just picked up/handed out. Also, please use for Health Department Staff showing EPSDT Video as one contact/event in the community regardless of location. *Includes Passport Counties.*)

07 – Community Planning Activities*
Intended to measure activities in which staff are involved with the community working toward a common goal of improved health for its citizens. Examples of community planning activities include but are not limited to assessing the community's health problems, serving on community groups/coalitions, and activities related to APEX-PH, PATCH, and the transition model. Report each activity separately, but do not report ethnicity, gender, age or total participants. (Use for EPSDT Outreach when working with Private Providers to promote EPSDT Screenings. *Does not include Passport Counties.*)

08 – Other Activities
This activity code is to be used ***only*** as a last resort for activities that will not fit into one of the categories defined above. *(Not to be used for EPSDT Outreach.)*

09 – Health Fair*
Interactive, non-interactive, general, and specific topic presentations to community groups or other groups of people in a health fair setting that is not required to be reported in the Supplemental Reporting System. Report each presentation separately but do not report ethnicity, gender, age and total attendance.

Examples of health fairs include: an unmanned booth at the grocery store on the importance of eating five fruits and vegetables per day or a booth at a work site with material on the importance of monthly breast self-exams. *(Not to be used for EPSDT Outreach.)*

10 – EPSDT Only – Face to Face
Outreach for EPSDT, in person, other than in a home visit, to either a child listed as New Eligible or a child not known to be listed as New Eligible, in the Health Department or in the School or Community. *Includes Passport Counties.*

11 – EPSDT Only – Phone
Outreach for EPSDT, by phone, including messages, to either a child listed as New Eligible or a child not known to be listed as New Eligible, in the Health Department or in the School. *Includes follow-up in Passport Counties*.

12 – EPSDT Only – Home Visit
Outreach for EPSDT, through a home visit, attempted or successful, to either a child listed as New Eligible Listing or a child not known to be listed as New Eligible in the Health Department or in the School. *DO NOT use in Passport Counties.*

13 – EPSDT Only – Letter
Outreach for EPSDT, by mail, including all letters mailed, to either a child listed as New Eligible Listing or a child not known to be listed as New Eligible, in the Health Department or in the School. *Includes follow-up in Passport Counties.*

14 – EPSDT Only – Appointment Made
Making an appointment for EPSDT Screening either at the Health Department or Private Provider's Office for any eligible child, listed as New Eligible or not known to be listed as New Eligible, in the Health Department or School.

15 – EPSDT Only – Mailed/Provided KCHIP Application
Outreach for KCHIP enrollment through face to face encounter, mail or fax, by providing a KCHIP application to a parent or guardian of any child not known to be elgible for Medicaid or KCHIP.

16 – EPSDT Only – Completed KCHIP Application
Outreach for KCHIP enrollment through face to face encounter, phone or fax, by helping a parent or guardian to complete a KCHIP application for any child not known to be eligible for Medicaid or KCHIP.

17 – EPSDT Only – Submitted KCHIP Application
Outreach for KCHIP enrollment through face to face encounter or fax, by helping a parent or guardian to submit a KCHIP application for any child not known to be eligible for Medicaid or KCHIP.

*Should be used with Place/Type of Service Codes 14-16 EPSDT Only.

TO ENTER NEW DOCUMENTS

COMMAND:
COID<Space><HID(your HID# here)**><Space><N><XMIT>**

A Community Health Services Reporting label is printed automatically when document is entered and is to be affixed to CH-48 form.

TO RETRIEVE ENTERED DOCUMENT FOR CHANGING/DELETING

COMMAND:
COID<Space><HID(your HID# here)**><Space><Doc#><XMIT>**

A Community Health Services Reporting label is printed automatically when document is entered and is to be affixed to CH-48 form.

TO CHANGE DOCUMENT: Make changes on screen then xmit screen.

TO DELETE DOCUMENT: Change Act [ ] from 'C' to 'D' then xmit screen, system will print a "deleted" document label.

Action Codes: *N - for new record*
C - for change to existing record
D - to delete an existing record

	County of Service	Lead Provider#	Date of Presentation /Meeting	Place/ Type of Service	Cost Center	2010 Objective/ Program	Strategy #	Activity Code	*Race ***						**Ethnicity ***	***Gender		***Age					
									W	B	N	A	H	U	L	M	F	<5	5-12	13-18	19-49	50-64	65+
1																							
Description:																							
2																							
Description:																							
3																							
Description:																							
4																							
Description:																							
5																							
Description:																							
6																							
Description:																							

	Total # Contacts/ Participants	Contact Time (minutes)***	Prep Time (minutes)***	# Cases	Agencies	Causes	Optional LHD Field	Optional LHD Field	Data Entry Initials/Date
1									
2									
3									
4									
5									
6									

***W=White**
B=Black
N=American Indian or Alaska Native
A=Asian
H=Native Hawaiian or Other Pacific Islander
U=Unknown

****L=Hispanic or Latino**

*****Enter actual number for:**
RACE ETHNICITY GENDER AGE

*****15 minute increments**

Activity 1 Label	Activity 2 Label	Activity 3 Label
Activity 4 Label	Activity 5 Label	Activity 6 Label

COMMUNITY BASED SERVICE CODES

PLACE/TYPE OF SERVICE CODES

01	School
02	Worksite
03	Health Department
04	Community (general)
05	Other Agency/Institution
08	Newspaper/Newsletter
09	Radio
10	Television
11	Website
12	Other Media
13	Billboard

ONLY 14-18 To Be Used for EPSDT Outreach

14	EPSDT Only – Private Providers
15	EPSDT Only – School System
16	EPSDT Only – Community Events
17	EPSDT Only – New Eligibles
18	EPSDT Only - Other Than New Eligible

COST CENTERS

***Note: The Cost Center number input must correspond with the Cost Center number the activity falls under in Community-Based Plans, if included in plan. If activity was not included in plan, choose the most appropriate Cost Center.**

722	Asthma Education
735	COPD
736	Healthy Communities
801	Immunizations
804	WIC
805	Nutrition
806	TB
807	STD
813	Breast and Cervical Cancer
818	Community
830	Cancer Coalitions
832	Heart Disease or Stroke
833	Breastfeeding Regional Coordinator
843	HIV
856	Arthritis
857	Physical Activity or Osteoporosis
883	EPSDT Outreach (for use with program code 120E0 only)
890	Core Community Assessment

2010 OBJECTIVES/PROGRAM CODES

***Note:** **When reporting activities, 2010 Objectives/Program Codes should match the ones used in the Community-Based Plans.**

ACTIVITY CODES

01	Health Promotion/Education
02	Behavioral Change Education
03	Professional Education for Health Care Providers and Educators
04	Information & Material Distribution
07	Community Planning Activities
08	Other Activities
09	Health Fair
10	EPSDT Only – Face to Face
11	EPSDT Only – Phone
12	EPSDT Only – Home Visit
13	EPSDT Only – Letter
14	EPSDT Only – Appointment Made
15	EPSDT Only – Mailed/Provided KCHIP Application
16	EPSDT Only – Completed KCHIP Application
17	EPSDT Only – Submitted KCHIP Application

AGENCIES

1	Coroner
2	Law Enforcement
3	Department for Community Based Services
4	Local Health Department
5	Attorney
6	Emergency Medical Service
7	Fire
8	Other

CAUSES

1	SIDS
2	Illness or Other Natural Cause
3	Drowning
4	Vehicular
5	Suffocation/Strangulation
6	Fire/Burn
7	Undetermined
8	Prematurity
9	Falls
10	Poison/Overdose
11	Homicide
12	Suicide
13	Other

EPSDT/KCHIP OUTREACH REPORTING

(For Use by Clinic Staff)

PAYPERIOD ENDING ___/___/___ **COST CENTER *883* / FUNCTION CODE *125***

NAME _____ I.D. # _____ COUNTY CODE_____

DATE *(Month/Day)*	SERVICE CODE	ACTIVITY CODE *(Enter total # completed of each activity)*	TOTAL #	TIME FACTOR *(see back page)*	TOTAL TIME
Monday	17	10☐ 11☐ 13☐ 14☐ 15☐ 16☐ 17☐		X.25	
/	18	10☐ 11☐ 13☐ 14☐		X.25	
Tuesday	17	10☐ 11☐ 13☐ 14☐ 15☐ 16☐ 17☐		X.25	
/	18	10☐ 11☐ 13☐ 14☐		X.25	
Wednesday	17	10☐ 11☐ 13☐ 14☐ 15☐ 16☐ 17☐		X.25	
/	18	10☐ 11☐ 13☐ 14☐		X.25	
Thursday	17	10☐ 11☐ 13☐ 14☐ 15☐ 16☐ 17☐		X.25	
/	18	10☐ 11☐ 13☐ 14☐		X.25	
Friday	17	10☐ 11☐ 13☐ 14☐ 15☐ 16☐ 17☐		X.25	
/	18	10☐ 11☐ 13☐ 14☐		X.25	
Saturday	17	10☐ 11☐ 13☐ 14☐ 15☐ 16☐ 17☐		X.25	
/	18	10☐ 11☐ 13☐ 14☐		X.25	
Monday	17	10☐ 11☐ 13☐ 14☐ 15☐ 16☐ 17☐		X.25	
/	18	10☐ 11☐ 13☐ 14☐		X.25	
Tuesday	17	10☐ 11☐ 13☐ 14☐ 15☐ 16☐ 17☐		X.25	
/	18	10☐ 11☐ 13☐ 14☐		X.25	
Wednesday	17	10☐ 11☐ 13☐ 14☐ 15☐ 16☐ 17☐		X.25	
/	18	10☐ 11☐ 13☐ 14☐		X.25	
Thursday	17	10☐ 11☐ 13☐ 14☐ 15☐ 16☐ 17☐		X.25	
/	18	10☐ 11☐ 13☐ 14☐		X.25	
Friday	17	10☐ 11☐ 13☐ 14☐ 15☐ 16☐ 17☐		X.25	
/	18	10☐ 11☐ 13☐ 14☐		X.25	
Saturday	17	10☐ 11☐ 13☐ 14☐ 15☐ 16☐ 17☐		X.25	
/	18	10☐ 11☐ 13☐ 14☐		X.25	

- Enter last day of payroll week at top left corner of sheet
- Enter Name at top of page
- Enter Employee ID #
- Enter County Code
  - *If you are working in different counties during a pay period you will need to identify which counties you are reporting to for which dates **or** put them on separate forms*
- Service ***Code 17*** is "New Eligible," **(Passport cannot report)**
  (to code New Eligible the client has to be on the 708 Report for that month)
- Service ***Code 18*** is " Other Eligible"
- Activity ***Code 10*** is "Face-to-Face" EPSDT consult
- Activity ***Code 11*** is "Phone"
- Activity ***Code 13*** is "Letter"
- Activity ***Code 14*** is "Appointment Made"
- Activity ***Code 15*** is "Provide/mail KCHIP Application"
- Activity ***Code 16*** is "Completed KCHIP Application"
- Activity ***Code 17*** is "Submitted KCHIP Application"
- If you are coding more than one activity code for the same day you will need to identify how many contacts to each activity code. Enter into the appropriate box the total # completed for each activity.
- Total number of ALL activities provided for one day
- If you outreach at least one (1) person on any given day, the minimum amount of time you code is .25 (15 minutes)
  - *If more than one in family, document the number and reduce time accordingly*
- Enter total amount of time for each day on EPSDT Outreach Form (CH-48EO)
- **Enter total time for each day to code 883-125 on Timesheet**
- **Turn in with timesheet to supervisor with your timesheet for that payperiod**

Clinic support staff may use, *within reason*, the following patient #s and amounts of time; Clinic provider staff should report actual time spent on **EPSDT Outreach**; it is based on **face-to-face** outreach (*you can provide an EPSDT Handout*); the amount of time documented and reported needs to be as close to actual outreach time as possible; you should also take in consideration time when more than one family member is eligible for EPSDT outreach:

# of people provided EPSDT information	Estimated Amount of time
1-4	.25
5-8	.50
9-12	.75
12-15	1.0

APPENDIX I

EARLY PERIODIC SCREENING, DIAGNOSIS, and TREATMENT (EPSDT) Program

- Good preventive health care for your child is important and is provided FREE to you!
- The EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Program pays for regular medical and dental checkups for children and young adults under 21 years old who have a Medicaid card or a KCHIP card.
- The health care check-ups are free for all children and adolescents who have Medicaid and are under 21 years of age.
- Regularly scheduled check-ups are important in order to find and treat hidden health problems and prevent future health problems such as obesity, asthma, diabetes, vision and hearing and mental health disorders before they become serious.
- Children under 3 years of age should receive several check-ups every year.
- A health care check-up might include medical history, physical growth and assessment, test for eyesight, hearing, low iron in the blood, tuberculosis and shots to prevent diseases such as measles and lockjaw.
- It is also important for all children under the age of 6 to get a blood lead screening.
- A check for mental health status for appropriate milestones is important.
- Dental check-ups should occur at the eruption of the first tooth.
- If you are in the managed care “Passport” region (Jefferson County and surrounding 15 counties) and need help making an appointment for check-ups for your child, call Passport.
- If you are not in the managed care region, and need help making appointments call your local Department for Community Based Services (DCBS) worker, where you signed up to get Medicaid.
- If you need a ride to the health care check-up appointment, you may request non-emergency medical transportation. If a health problem is found, the screening provider will help you make an appointment to get treatment for your child.
- EPSDT Special Services are also available for Medicaid eligible children under 21 years old who need medical services or items not covered by other Medicaid Programs.
- These services can include special therapies, dental services, substance abuse treatment and more.
- If you want to know more about these services, call Member Services at 1-800-635-2570.
- If you would like to complete an application for Medicaid or KCHIP benefits or need assistance to complete an application, you can go to your local DCBS office or we can help you complete and submit the application by mail or fax.

WHAT SERVICES CAN YOUR CHILD RECEIVE IN THE EPSDT PROGRAM?

- Medical history and physical exam, which includes an evaluation of your child's physical and mental growth and development
- Vision test
- Hearing test
- Dental Exam
- Shots
- Health Education
- Laboratory tests, such as urine and blood tests
- Referrals to another medical provider if your child needs more services

HOW CAN YOU OBTAIN THESE SERVICES?

- Your KenPAC physician, PCP (Primary Care Provider), local Health Department,or other provider can provide EPSDT services.
- Your case worker at the local Department for Community Based Services or your health plan's Member Services Department can assist you with scheduling appointments and arranging transportation.
- Let us give our children the best we can. Using the EPSDT Program is a good start.
- If your child has a KenPAC physician, a PCP, or if you visit the local health department, ask them about EPSDT services.

EPSDT SPECIAL SERVICES (TREATMENT)

- In addition to the preventive health care described above, treatment services may also be available for your child under the EPSDT Special Services program.
- Please have your medical provider call Member Services at 1-800-635-2570 for additional information on this program and how to obtain services.

NOTE: Children who are covered through the Kentucky Children's Health Insurance Program (parents pay a $20 premium for coverage) are NOT eligible for EPSDT Special Services or for Non-Emergency Medical Transportation.

APPENDIX II

1. **What is EPSDT?**
   A children's preventive health examination or a children's health check up

2. **What does EPSDT stand for?**
   Early **P**eriodic **S**creening, **D**iagnostic and **T**reatment

3. **What is the doctor or nurse checking during my child's (children's) EPSDT exam(s)?**
   Your child's general health will be checked. This includes an examination of your child's: eyes, ears, and teeth. The doctor or nurse will also check to see if your child is growing normally.

   Your child will be given shots, if needed. Shots help protect against measles, mumps, polio and other serious illnesses.

   Your child will be checked for some diseases as well as problems in growth and development. Your child may be checked for heart, lung and kidney problems, tuberculosis, eye, ear, nose and throat problems, lead poisoning, mental health problems and other health problems.

   If a problem is found, it may be treated right away or need to be checked further before treatment begins.

4. **Why is my child's EPSDT check up important?**
   Children's doctors recommend regular exams to make sure your child is healthy by finding and treating problems before they get worse.

5. **How will these services benefit my child?**
   Exams can prevent illnesses and disabilities and spot problems so they can be treated before they get worse.

6. **How can my child get these services?**
   If your child has a Medicaid or KCHIP card, you don't have to sign up for another program to get EPSDT services for your child. To qualify your child must be eligible for Medicaid or KCHIP, the Kentucky Child Health Insurance Program. When you call your doctor or the health department for an appointment; say you want an EPSDT exam. When your child goes for an exam, take these things with you: any shot records,your child's Medicaid or KCHIP card, and the name of your child's doctor.

7. **What if my child does not have a Medicaid or KCHIP card?**
   If your child does not have private insurance and you are concerned that you can't afford to take your child to the doctor, call your local health department, community based services office or doctor and ask how you can get a Medicaid or KCHIP card for your child.

8. **Who are the providers of EPSDT services?**
   Your local health department and some local doctors, including your KENPAC doctors.

9. **What are EPSDT special services (any services that are medically necessary but not generally covered by Medicaid)?**

   Examples are mental health services, speech therapy, or bath chairs. Your Kenpac or doctor may not be aware that Medicaid pays for these services. If there is a problem in getting a special service that your child needs, please ask your KENPAC doctor, family or children's doctor to call or you may call the Medicaid program at (502) 564-6890. It is important to know that KCHIP benefits do not pay for EPSDT special services and non-emergency transportation.

10. **Do you need help to make an appointment or to get transportation?**
    If you need help to make an appointment or to get transportation to the appointment, Health Departments can help you find these services. You can contact your local Department for Community Based Services Office or managed care organization for assistance with transportation, if needed.

APPENDIX III

Could your child be eligible for Medicaid or KCHIP benefits?

- Children need health insurance – even when they are not sick.
- Check-ups and well child visits help keep children healthy.
- To make sure every child can apply for medical benefits, the Kentucky Children's Health Insurance Program (KCHIP) has a new mail-in application.
- If you would like to apply for medical benefits for your child, we can help you by sending you an application.
- Although the application cannot be submitted by telephone, you can call us and we will talk you through the application while you fill it out or you can come in person and we will help you complete the application at your convenience.
- Or, you can get a mail-in application by calling toll free 1-877-524-4718, emailing Kidshealth@ky.gov.or by logging onto the KCHIP website http://www.kidshealth.ky.gov/en/kchip/apply.htm,
- Fill the application out and attach the documents we ask you to provide and we will see if your child can get medical benefits.
- You will not have to come to the office unless we cannot get all the information we need through the mail.
- If you have questions or need help filling out the application, contact NAME at the NAME OF Health Department by calling HEALTH DEPARTMENT PHONE NUMBER or call the toll free number, 1-877-524-4718, and someone will help you.